Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9:05am M 2011 January Dillow Virginia Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 8. Date of Birth Birthpiec Country) VA Funeral 7. Age (In vrs. last birthday) (Month, Day, Months Days Hours Min. 1 🗆 M 2 💢 F Director 84 212-36-4424 October Usual Residence of Deceden 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location at Director be notified 1 Yes 2 No Owings Mills MD Baltimore 10e Street and Number 5 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a must USA 409 Chattolanee Hill Road 21117 death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Examiner Armed Forces Black, White, etc. "natural", or à 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No within 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: 3 X Widowed 4 ☐ Divorced Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Worker Residential 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve Stella Mae Hall Frank E. Repass 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrew_Dillow Son 5906 Sunset Ave., Baltimore, MD Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) <u>Evergreen Mem. Gardens</u> 1/14/11 Finksburg, MD Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Tep non Reisterstown, MD 21136 Eline Funeral Home 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between hysician/ Onset and Death Immediate Cause (Final meta static paneventic rech disease or condition Medical resulting in death) Due to (or as a consequence of) xaminer Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of). resulting in death) Last physician Physician/Medical that the death certificate be Box 68760 attending physical for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live Birth 2 - Fetal death in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death ed by the g Unknown g Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed t 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 VNo 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law autopsy performed certificate 1 Yes 2 No Yes 2 No 24 hours after death.

Funeral Director: After this certifical eted filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home \(5 \sum \) Residence \(6 \nabla \) Other (Specify) 2 PNo မ 1 Inpatient 2 ER/Outpatient 3 DOA MOSPIC & 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 27. Manner of Death Certificate: 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou To the Funer completed fil Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the 29b. Signature and title of certifier 2 29c. License number 29d. Date signed (Month, Day, Year) P0070636 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W Suite 4105 Bultmere dip 212071 tel Churies 1200 2 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

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2011

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			1 - For State Registrar	State of Mar		artment of l		and Me		giene Reg. No.	*	01002
	Physicia Medic		1. Decedent's Name (First, Middle, Last) James Stewart E	hrhart S	Sr.				2. Date of Dea Januar		Year	3. Time of Death 7.55 \$ M
	Examin		4a. Facility Name (if not institution, give stre Summit Park Heal		Rehab	4b. City, Town, or Catons				4c. County Bal	of Death tim	ore
	Funeral Director		5. Social Security Number 6. Sex XXM		n yrs. last birthday) 2 Yrs.	If Under 1 Year Months Days	If Under 2 Hours		8. Date of Birth (Month, Day 0 1 / 1 8 /		9. Birth Cour	place (State or Foreign ntry) MD
	ryland -f show ied at	ctor	Usual Residence of Decedent 10a. State 10b. County MD Howard	10	Oc. City, Town or Lo	ridge						10d. Inside City Limits 1 ☐ Yes 2 No
	th the Ma 3a or 28a t be notif	Funeral Director	10e. Street and Number 6599 Pheasant Dr.	ive		10f. Zip Code 210	75	-		10g. Citizen of V	/hat Cou	
20	after death wi I", or items 2 xaminer mus	è		Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates 9 5	1	Was Decedent of H If Yes, specify Cuba	ispanic Orig ın, Mexican,	jin? (Speci , Puerto Ri	fy Yes or No- ican, etc.)	14. Race	k, White,	
0500-6171	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Seconday (0-12)	ition	16a. Dece (Give life. D	dent's Usual Occup kind of work done o O NOT use retired) nsulato	during most	of working	7	16b. Kind of Bu	siness Ir	
ylandz	d be filed w Mental Hygi arked other atic event, t	To Be	17. Father's Name (First, Middle, Last) Unavailable					r's Name (Un	First, Middle, M availa	Maiden Surname able)	
Mar	id 2 shoul salth and I n 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Maria Lynn Ehrha:			ng Address (Street a 9 Pheas						
pairimore	Page 1 an nent of He ant: If iten iry or oth		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)		20b. Place of Dispo cemetery, cree Atlanti	matory or other place	:e) /	Da		20c. Location - Glen E	-	
ספונ	permit. Departr Imports any inji		21. Signature of Funeral Service Licensee	1hm	7 T	2. Name and Address homasAl	ss of Facility	Simp	plicit 090 Ri	y Crem	ı & Han	Fun Serv over MD
٦,	nysician/		23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one commediate Cause (Final disease or condition	ause on each line.	e death. Do not ent		g, such as c					Approximate Interval Between Onset and Death
1	Medical Examiner	L	resulting in death) Sequentially list conditions, b.	Due to (or as a co	onsequence of): 2rusclero	tic hears	- disc	eus e				104-8
7	ured id ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events	Due to (or as a co	omorry c	tic hear	dise	ase			- 1	(1
3	atri cermicate be executed attending physician and for use as the burial-transit	dical	resulting in death) Last	Due to (or as a co	presequence of):						\perp	15425
. DOX DOD .	A wending Prysician: The law requires that the death certifical site attending property. After this certificate has been signed by the attending print by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of £ 1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal death 3	Ectopic pregnand Other (specify)	ey .			23d. Dat Mor		ery Day Year
Olds, r.O	ures trat to in signed by uld be deta	ρ	Part II. Other significant conditions contril	ive Luna		, 0	en in Part I.					he cause of death?
	rne raw require cate has been si page 2 should I	Completed	Diabetes mellit	us					24a. Was a autops perfori	med?	rior to co eath?	psy findings available impletion of cause of 2 No
AICO	iysician: The his certificate director, page	To Be	25. Was case referred to medical examiner? 1 Yes 2 No		2 ☐ ER/Outpaties	Othe	ace of Death		7	ence 6 ☐ Othe	r (Specifi	·
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	of the hospital of Attending within 24 hours after death. To the Funeral Director: After completed filled in by the fun		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S		eet, factory, office		28	3f. Location (St City or Town	reet and Numbe n, State)	r or Rura	l Route Number,
100	n 24 hou n 24 hou ne Funer	Medical	29a. Certifier 1 Certifying Physicia (Check 2 Medical Examiner: only one) 3 Certifying Nurse Pr	On the basis of exam	ination and/or inves	tigation, in my opinic	n, death occ	curred at th	ne time, date an	d place, and due	to the ca	use(s) and manner stated.
F	vithi To tl	_	29b. Signature and title of certifier	- *r	DESHIM D	29c. License	number	4	2	29d. Date signed		
	11		30. Name and address of person who comp	eleted cause of death	(Item 23a) (Type, F	Print) e lane f			2 00			
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's	Signature for	Kel						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ onth Medical 4a. Facility Name (if not institution, give **Examiner** City, Town, or Location of Death 4c. County of Death (In yrs. last birthday) Birthplace (State or Foreign Country) 7. Age 8. Date of Birth **Funeral** Months Hours Min **Director** or items 23a or 28a-f show 10b. County 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits 1 Yes 2 No timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 72 hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White, etc Yes 2 No Completed by 1 Never Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Specify "natural", 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than . Page 1 and 2 should be filed within ment of Health and Mental Hygiene. tant: If item 27 is marked other than College (1-4 or 5+) intainance Be 17. Father's Name (First, Middle, Last) 18. Mother's I ဂ t's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ٤ permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other: other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place Signature of Emeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on Interval Retween Immediate Cause (Final Onset and Death ₽h sician/ disease or condition resulting in death) ad Medical a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year Yes 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has I autopsy perform 1 🗌 Yes 1 🗌 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Tes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral C 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certi 30. Name and address of person who complete ause of death (Item 23a) (Type, Print)

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State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Farmer Month Year M. Audres 11:24PM January 20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel 407 Carl Avenue Linthicum Heights Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth Birthplace (State or Foreign Country)
 Cklahora **Funeral** Year) 1916 94 August 28 408-82-3729 Director Usual Residence of Decedent r show be filed within 72 hours after death with the Maryland : If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Anne Arundel County Linthiam Heights Maryland 1 Tes 2X No 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 407 Carl Avenue 21090 United States of America 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: If Yes, Give Specify: White Completed 3 X Widowed 4 □ Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homenaker 8 Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ella Ruebling Amold McGarvin permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Smoot -- Grandbauchter 407 Carl Avenue, Linthiaum Heights, Maryland 21090 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Xxremation 3 Removal from State Evans Funeral Chapel and Cramation Services Belair 4 Donation 5 Other (Specify) Forest Hill, Maryland Jan. 20, 2011 21. Signature of Funeral Service Licenses P. Name and Address of Facility Fivans Funeral Charcel and Cremation Services 8800 Harford Road, Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Alsterners Dementia Immediate Cause (Final Onset and Death End -STAGE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be execuled Cause (Disease or linjury that initiated events resulting in death) Last been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death
Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 🖪 No 3 🗌 Probably 4 🔲 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed? After this certificate funeral director, pag 1 ☐ Yes 2 ☐ No 2 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No ျပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident 1 🗌 Yes 2 🗌 No Investigation after death Director: / Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

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completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, nskajapahnem. D D0057465 1/18/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5-703 - Baltimore, MD. 21209. 2835 Smith N-NS. RajapakseiM.D

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State

Registrar

31. Date filed (Month, Day, Year)

JAN 20 2011

32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Day Physician/ Year Fink, William . Sr. Η. 2011 1:15 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 435 South 52nd Street Baltimore Baltimore County 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Months Hours Country) Pennsylvania Director 205-20-5846 84 Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notitied at any injury or other traumatic event, the Medical Examiner must be notitied at any injury or other traumatic event, the Medical Examiner must be notitied at any injury or other traumatic event, the Medical Examiner must be notitied at any injury or other traumatic event, the Medical Examiner must be notitied at any injury or other traumatic event. 10a. State 10c. City. Town or Location 10d. Inside City Limits Director Baltimore Co. 1 Yes 2 X No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 435 South 52nd Street United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give Black, White, etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify. 3 Widowed 4 Divorced Completed Year or Dates Korean White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Years Steel Industry Steelworker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ruth Frances Wilbur Franklin Fink 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7815 Bank Street Baltimore, Maryland Mr. William H. Fink, Jr. (Son) 21224 0a. Method of Disposition 20b. Place of Disposition (Name of Gazeriesomem Romoester place) t. 25 17/2011 20c. Location - City or Town, State
UWINGS MILLS XBurial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Achton Willow Spring f Funeral Service License Name and 21. Signatu Dundalk 21222 Dundalk, Maryland 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician WAR disease or condition) Medical resulting in death) as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that believed as entered in the cause (Disease or injury that is the cause (Disease or iinjury that is the cause or injury that is the cause of th Examine attending physician and for use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Dav ☐ Yes ∠ L ☐ Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: autopsy perform 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 (Assidence 6 \(\sum \) Other (Specify) ၉ 1 🗌 Yes 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 DOA . Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred s after dec. Natural 5 \square Pending 1 🗌 Yes 2 🔲 No Investigation Accident 3 ☐ Suicide 4 ☐ Homicide To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number
DUUG8020 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AM2 HAROUN, 4D 1245 EDSTERN B(VI), BA(TIMORE, MD 21221 HI

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Registrar

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician/ 17 02:10 A M Jan. 2011 Patricia Ann Gross Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Gilchrist Hospice Center Baltimore If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday, 1 □ M 2 📭 Days Aug. 15 51 ∜959 Maryland Yrs. **Director** 216-78-4976 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** be notified 28a-f 1 🗆 Yes 2 🎦 No Sparks Maryland Baltimore 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a (mst pe USA 15809 Yeoho Road 21152 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※XX No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or itel Black, White, etc. Completed by 1★ Never Married 2 ☐ Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene.
Important if item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin. 1 ☐ Yes If Yes, Give 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (C-12) College (1-4 or 5+) Self Employed 12th grade Private Duty Nurse Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mabel Brown Nathaniel Gross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15809 Yeoho Road Sparks, MD 21152 Mabel Smith/ Mother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 Burial 2 Cremation 3 Removal from State Green Mount Cemetery 1-20-2011 4 Donation 5 Other (Specify) Baltimore, MD 21. Signature of Saneral Service License 22. Name and Address of Facility Chatman-Harris Funeral Home Herris 5240 Reisterstown Road Baltimore, MD 21215 a. Part . Enter the divides, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Fin Onset and Death Rhysician/ reast disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 N No
9 Unknown Month Day Year P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? after death.

Director: After this certificate 2 🗌 No Yes the Hospital or Attending Physician: thin 24 hours after death. Division of Vital completed filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) WSPILL 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 🔲 Yes 2 🗆 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical 29a. Certifier 📜 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Registrar
DHMH 17 Rev 7/2009

State

JAN 20 2011

201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11-00432
Luther Gorham

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

uther Gorham		1- For State Registrar	ate of Maryla		artment o <i>rtificate o</i>		Mental H	F	Reg. No. 201	01007
Physici Medical Exami		Decedent's Name (First, Middle	,Last)					Date of Dea Month	Day Year	3. Time of Death 1025 hrs
MECICAI EXAIII	IIGI	Luther Gorham 4a. Facility Name (if not institution	n, give street and nur	nber)		4b. City, Town, or L	ocation of Death	January 1	15, 2011 4c. County of Dea	
F		St. Agnes Hospital	, ,	,		Baltimore			N/	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24Hrs		irth(MM/DD/YYYY) 9. B	irthplace (State or
Director		214-64-0899	1 ✓ M 2 F	55	Yrs	Months Days	Hours Min	Tebruary	7 16, 1955 NS	r u yCarolina
		Usual Residence of Decedent								T
w any		10a. State 10b. County		10c. City	, Town or Loca	tion				10d. Inside City Limits 1 V Yes 2 No
Maryland 28a-f show d at once.	ţ	MD 10e. Street and Number	N/A	Balt	imore	1405 7:- 0 - da			40 - Citizan - CAMbat Ca	
e Mar or 28a	Director					10f. Zip Code		į	10g. Citizen of What Co	and y c
eath with the Maryland items 23a or 28a-f sho ust be notified at once.		808 Winston Ave		edent Ever in U	S 13 W	21212 as Decedent of Hisp		necify Yes or No	USA	rican Indian, Black,
eath v	Funeral	1 Never Married 2 V Ma				es, specify Cuban,			White, etc.	
ifter d	by Fi	3 Widowed 4 Divo	orced If Yes, Give Yaar or Dates:		1	Yes 2 No	specify:		Specify: Bl	ack
naturi Xami		15. Decedent's Education (Spec	ify only highest grade	e completed)		nt's Usual Occupation			16b. Kind of Business Housing Auth	/Industry
36 n 72 h nan 4, ical E) je	Elementary/Secondary (0-12)	College (1-	4 or 5+)					Baltimore Ci	_
-00. I withi giene. Iher ti	Completed	12th Grade 17. Father's Name (First, Middle, I	(ast)		Firs	st Grade I			Maiden Surname)	Ly
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho marite event, the Medical Examiner, must be notified at once	Be	Luther Gorham,	,				orothy 1		,	
21215 ould be file d Mental H marked it event, it		19a. Informant's Name/Relationsh			19b. Mailin	g Address (Street	and Number or f	Rural Route Nu	mber, City or Town, Stat	e, Zip Code)
MD d 2 sho lith and n 27 is numeti		Sheila Gorham -	Wife						, Maryland	
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma Injury or other traumantic	- 1	20a. Method of Disposition 1	3 Removal fro		Place of Dispos crematory or ot	sition (Name of ceme her place)	etery,	Date	20c. Location - City of	r Town, State
Baltimore, permit. Pages 1 a Department of He Important: If its		4 Donation 5 Other Spe	ącify:	- 1		Cemetery		2/2011	Lansdowne,	Maryland
Ball Sermit Depart Impor		21. Signature of Funeral Service/L	icensee			lame and Address	: Chat	man-Harr	is Funeral Ho	me_
Physician	-	23a. Part I, Enter the disease, or o	complications that ca	used the death	DO not enter t	J Kelstersto he mode of dving, s	uch as cardiac o	r respiratory arr	Maryland 212	Approximate Interval
(Medical		23a. Part I. Enter the disease, or of failure. List only one cause of Immediate Cause (Final disease	n each line. Py	eloneph eroscl	ritis (Complicat Cardiovas	ing Hype cular D	rtensiv isease	ve during	Between Onset and Death
£xaminer		or condition resulting in death)	Due to (or as a c	consequence of	rocedu f):	re for En	d Stage	Kenal	Disease	
		Sequentially list conditions,	b							
and .	ji.	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a c	consequence o	or):					44
19 g g	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence o	of):					
Division of Vital Records, P.O. Box 68760, Bospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and redy filled in by the funeral director, page 2 should be detached for use as the burial - transi	edical	X UNPENDED	d AMENDED	23a,27	per me	g914 4-2	8-11 vt			
760, cate be physic he bur	Med	IF FEMALE:	23c. If yes, or	utcome of preg	nancy				23d. Date of delive	ту
30x 6876 leath certificate e attending phy for use as the l	7	23b. Was decedent pregnant in the past 12 months?	1 Live bir		2 Fe	tal death 3	Ectopic pregna	incy	Month	Day Year
30X death e atter	Physici	1 Yes 2 No 9 Unkr	I . L		5 Ot	her (Specify)			1	
O. B. at the de d by the a		Part II. Other significant condition	ons contributing to	death but not r	esulting in the u	ınderlying cause giv	ven in Part I.	23e. Did to	obacco use contribute to	the cause of death?
P.C. ires that signed I be deta	d by							1 Ye	s 2 No 3 Pro	bably 4 VInknown
Records, The law require ficate has been si	Completed		_					24a Was autor	psy prior to	utopsy findings available completion of cause of
Rec(The lar	E O								ormed? death? 2 No 1 ✓ Y	es 2 No
Vital Rec ysiclan: The his certificate director, page	Bec	25. Was case referred to medical examiner?					of Death (Check	only one)		
Physic r this cal dire	의	1 ✓ Yes 2 No			ER/Outpatient				Residence 6 Othe	er:
n of ding Ph. h. After t		27. Manner of Death 1 X Natural 5 Pendii		f Injury Day,Year)	28b. Time of I		at Work? es 2 No	28d. Describe	how injury occurred	
Sion Attendary death ector: by the	cati	2 Accident Invest	igation	of Injury - At h	ome farm stree	et, factory, office bui		28f Location /	Street and Number or R	ural Route Number, City
Divising pital or At ours after deral Direct filled in by	Certification:	3 Suicide 6 Could 4 Homicide determ	not be	o	omo, ram, ono	, , , , , , , , , , , , , , , , , , , ,	maning, etc.	or Town, S		and results trained, every
Hospi 24 hou Funer tely fil		29a. Certifier 1 Certifying Phy							se(s) and manner as sta	
Division To the Bospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 Medical Exam	niner:On the basis of and manner sta	examination a	nd/or investigat			t the time, date	and place, and due to t	ne cause(s)
	ž	29b. Signature and title of certifier	. /			29c. License		0145	29d. Date signed (Mo	
7		Theodon)	U. Ky	TR	u1)	O.C.M	.E. <i>U</i>	OME	January 16, 201	1
(ψ)		 Name and address of person version in the odore M. King, Jr., 				900 W. Baltimo	ore Street R	altimore MI	D 21223	
/ 0	ate			istrar s Signat		ooo II. Dakiiiik	oneer, D			
Reaist		31. Data flett growth, Day Year)	[Breezeway	A A	2.11.1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#3perphys, G911, 1/20/2011, WS
State of Maryland / Department of Health and Mental Hygiene
AMEND ITEM#16a, perff, G912, 2/1/2011, WS State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 3 Physician/ Froo mes eonara anaan 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A 3443 Roland Avenue If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral **1**XX M 2 □ F Months Days Hours Min. (Month, Day, May 21 1 Oklahoma 215-40-5885 Director 68 Usual Residence of Decedent 28a-f show 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director notified MD N/A Baltimore 1XX Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö ms 23a or must be r Funeral 3443 Roland Avenue 21211 U.S.A. er than "natural", or items the Medical Examiner mu permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Was Decedo... Armed Forces? → □ Yes XX No Black White etc. 1 Never Married 2XX Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes YV No Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired)

Plaster

Plasterer Elementary/Seconday (0-12) College (1-4 or 5+) Construction 11th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Willard Groomes Freda Loates 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sylvia J. Groomes (Wife) 3443 Roland Avenue Balto, MD 21211 20a. Method of Disposition
1 ⚠ Surial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State LakeView Memorial 1/17/11 Svkesville, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Burgee Henss-Seitz Funeral Home, 3631 Falls Road Balto,MD 21211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Leath Immediate Cause (Final Mesothelion Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence on attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: To the Hospital or Attending Physician; The law requires that the death certi within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attendin completed filled in by the funeral director, page 2 should be detached for use a 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death 9 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🗶 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 29a. Certifier Extrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0069329 M.D. Jan 2011 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) OF, MIA TANG 6569 N. Charles St. Suite 205, Baltion or e 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

			Please 1	AMEND TIEM 5,202	k Indelible Ink. Ensure	Il Copies Ar	e Legible.	0000
		•	For State Registrar	AMEND ITEM#SperF	k Indelible Ink. Ensure / -c, perfff, 6911, 1720/2 Repartment of Health and N Ertificate of Death	/iental Hyglen Reg. N	2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	11009
4	Physicia Medic		1. Dededent's Name (First, Middle, Last)	HOWARD		2. Date of Death Month Deunuary		3. Time of Death
	Examin	er	4a. Facility Name (if not institution, give s	reet and number) 7. Age (In yes. last birth	4b City Town or Rocetion of Death A J H H M D C	5	c. County of Death	(Cather Foreign
-	Funeral Director		Unk - 219 - 50 - 0851	Make 1	rs. Months Days Hours Min.	8. Date of Birth (b) th, Day (Vgar)	9. Birthplad Countryl	(Sate or Foreign
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	n with the is 23a or nust be r	Funeral D	100 Street and Number Ni Nu	ZERVE AVE	E. 10f. Zip Code 205	10g. C	itizen of What Country	?
900	within 72 hours after death with the Maryland glein. grethen "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.	Was Decedent of Hispanic Origin? (Spetif Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American I Black, White etc. Specify:	Indian, ICC
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If health and Mental Hygiene, it has the marked other than "natural", or items 23a or 28a-f show them 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at	Completed	15. Decedent's Edu (Specify only highest gradi Elementary Seconday (0-12)		Decedent's Usual Occupation Give kind of work done during most of work 19.00 NGT use retired)	ing 16b.	King of Business Indust	try
Maryland	ild be filed Mental Hygiarked oth atic event	To Be	17. Father Nama (First, Middle, Last)	DARD	18 Mother's Natur	e (First Middle Maider	10000 000 1000 1000 1000 1000 1000 100	N
	1 and 2 should of Health and M item 27 is mar other traumati		19agnformant's Name/Relationship (Typ)	19	Mating Andress (Street and Numberior Page	B HVBI	or road, state/zip Cod	Himor M
Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or otf		20a. Method of Disposition 1	emoval from State	Dispo in (Name of control of the place)	20c	Coation - City or Town	State
Balt	permit. Depart Import any inj		21. Signature of Funeral/Service Licenses	Duemre	22 Jame and Address of Facility	EAH	10/1/0	2/1/1
٦,	Physician/		shock, or heart failure. List only one Immediate Cause (Final	cause on each line.	ot enter the mode of dying, such as cardiac of		Int	oproximate erval Between aset and Death
)	Medical Examiner		disease or condition resulting in death)	Due to (or as a consequence of	c Colon Cano			
	ed	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to (or as a consequence of):			
	e be executed ysician and e burial-transit	-	that initiated events resulting in death) Last	Due to (or as a consequence of):			
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	ic. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day	y Year
ds, P.O.	quires that the dea en signed by the a uld be detached f	by	Part II. Other significant conditions con	ributing to death but not resulting in	the underlying cause given in Part I.		use contribute to the ca	A.
Division of Vital Records, P.O.	sician: The law require certificate has been si lirector, page 2 should	Completed				24a. Was an autopsy performed?	death?	etion of cause of
Vital	nding Physician: T th. : After this certifica e funeral director, p	To B	T LI fes ZALI NO	spital:	26. Place of Death (Check patient 3 DOA Other:	only one) me 5 Residence	6 ☐ Other (Specify)	
on of	nding Pl ath. r: After th e funera	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Tir inj	me of 28c. Injury at ury work? M 1 □ Yes 2 □ No	28d. Describe how inju	iry occurred	
Division	To the Hospital or Attend within 24 hours after death To the Funeral Director: completed filled in by the		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Street a City or Town, State	nd Number or Rural Ro. e)	ute Number,
	ne Hospi in 24 hour ne Funera pleted fill	Medical	(Check 2 L Medical Examine	r: On the basis of examination and/or	eath occured at the time, date and place, an investigation, in my opinion, death occurred at dge, death occurred at the time, date and place	the time, date and plac	ce, and due to the cause(s	
	To the with Com	_ [29b. Signature and title of certifier V. Koucuchou	L, Mi)	29c. License number	29d. D. Jeun	ate signed (Month, Day,	Year) 2011
	1		30. Name and address of person who con	npleted cause of death (Item 23a) (Ty	D63748 Memorical Hospite	I, Bellin	nore, me	my land
	Stat Registra	е	31. Date (Nonth, Day Year) JAN 20 2011	32. Registrar's Signature	,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #23PII per PHY Coll 1/20/2011 In
amend #25PII per PHY Coll 1/20/2011 In
state Amend Item 25 per me, golf 1/26/2011 Inb
Registrar

Continue of Decimal Physics 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1305PM Januar 2011 Anthony Hall Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A **Examiner** Baltimore Sinai Hospital Social Security Number 1 Year If Under 24 Hrs. 8. Date of Birth Birthpia. Country) . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 217-76-1453 1 🖾 M 2 🗆 F Months Days Hours Min. (Month, Day, Ye **Director** Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits Director N/A Baltimore 1 XYes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 USA 2519 Shirley Ave 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. African Armed Forces 1 K Never Married 2 Married ģ Yes 2 XNo 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Completed Amer. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 l n and Mental Hygiene. 7 Is marked other than "r Student Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Disability Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Mamie Hall permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once. John McCrady 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1603 Ingram Rd, Balt., MD 21239 Edward L. Hall/Brother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Security) cemetery, crematory or other place)
King Memorial Pk 1/22/11 Balt. cty, MD 21. Signature of Fur eral Service Licens 22. Name and Address of Facility Hari P. 5126 Belair Rd, Balt., 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Retween Immediate Cause (Final Onset and Death Physician/ Alaway 08
Due to (or as a consequence of) OBSTAUCT, ON week-5 disease or condition) Medical resulting in death) Examiner GOITER 442010 Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acute Repai Failure in signed t 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate h performed; 2 **V** No 1 🗌 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Certificate: To Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After it completed filled in by the funera 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) with 066810 2011 13 ANVARY N 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINAI HOSPITA L 2435 W. BUNEOURE BALTIMORE MI MD SHARON WEINTRA 31. Date filed (Month, Day, Year) Registrar's Signature State JAN 20 Registrar

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AMEND ITEM#19b, perFH, G911, 1/25/2011, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Lucy B. Henson 17 2011 1:45 P M Jan. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 215 Belmont Forest Ct. #307 Timonium Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day, Ye 1 🗆 M 2 🗓 F Months Days Hours Min. Country) Director 222-12-3310 Usual Residence of Decedent 28a-f show 10a. State 10b. County r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Timonium 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 215 Belmont Forest Ct. #307 21093 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 Xo
If Yes, Give
Year or Dates. Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify white 3 Divorced 4 Divorced Specify Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Attorney Estate Law other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental Fis marked or ပ Theresa DeVito Emmanuel Benedetto 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Rayle Yumber, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 215 Belmont Forest Ct. $\frac{\#202}{}$. Timonium, MD 21093 Edwin N. Henson/husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1/22711 any injury or 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Dulaney Valley Memorial Gardens Timonium, MD Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Rd., Timonium, MD 21093 Signature of Funeral Service Line once Mickael Flag 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Myelodysplastic

Due to (or as a consepplence of): Onset and Death Physician/ One year Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): and -transit Exami that the death certificate be executed Due to (or as a consequence of): inding physician a use as the burial-Physician/Medical Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Į. Day Year Pregnant at time of death signed by the a d be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 DANO 3 Probably 4 Unknown 1 🗌 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No 1 Yes Yes Division of Vital the Hospital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 No ဂ္ 1 Tes To the Hospital or Attending Physical within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) After this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 5 Pendina work? 1 ☐ Yes 2 ☐ No Accident
Suicide M Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 178 annany 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marshall Levine, M.D. GBMC West Pavilion Suite 205, Towson, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JAN 2 0 2011

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Benjamin	Harle

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njamin Harlee)	State of Maryland / Department of Certificate of			2011 g. No.	01012
Physicial Exami		1. Decedent's Name (First, Middle,Last) Benjamin Harlee		Date of Death Month	Day Year	3. Time of Death 2128 hrs
CUICAI EXAIIII	aci		o. City, Town, or Location of Deat	January 1,	4c. County of Death	
		Gilchrist Hospice Center	Towson		Baltimore Cou	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 219-52-5746 1 M 2 F 59 Yrs.	If Under 1 Year If Under 24Hr: Months Days Hours Min	_	h(MM/DD/YYYY) 9. Birl -1951 Foreig Con	
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	n			10d. Inside City Limits
	ō	MD na Baltimor	е			1 Yes 2 No
eath with the Maryland items 23a nr 28a-f ahm ust be notiffied at once.	Director	10e. Street and Number 3626 Columbus Drive	10f. Zip Code 21215	10	g. Citizen of What Cour	itry?
한 불의	Funeral	1 Never Married 2 Married Armed Forces? If Ye	Decedent of Hispanic Origin? (Ss, specify Cuban, Mexican, Puerto		14. Race - Americ White, etc. Specify:	can Indian, Black,
ours aft atural' camine	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent'	s Usual Occupation (Give kind of		16b. Kind of Business/II	ndustry
21215-0036 uld be filed within 72 hours after Mental Hygiene, marked nither than "natural", event, the Medical Examiner	Completed	8th grade Shipp	ing _C and Receing life. DO NOT use ret		Target	:
21215-0036 wild be filed within 7 Mental Hygiene. marked nither than c event, the Medical		17. Father's Name (First, Middle, Last) Ben Frank Harlee, Sr	18.Mother's Name		•	
D 212 should be and Ments 7 is mark	To Be	19a. Informant's Name/Relationship (Type, Print)	Address (Street and Number or		oer, City or Town, State,	, , , , , , ,
₹2 ± 2 m		4	9 Daybreak Te			
Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and N Important: If item 27 is n injury or nither traumatic.		1 X Cromption 3 Remarkal from State Crematory or other			20c. Location - City or Randalls Balto.MD	
Salti ermit. Departm mports ojury o		21. Signature of Funeral Service Licensee 22. Na	me and Address of Facility Ma	arch Ea	St F/H	
Physician	-	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the	101 E. North mode of dying, such as cardiac of	or respiratory arres	st, shock, or heart	MD 21202 Approximate Interval
/Medical		failure. List only one cause on each line. Head and Neck I Immediate Cause (Final disease a. Head Injuries with Complications	njuries with Co	mplicati	lons	Between Onset and Death
_Adminer		or condition resulting in death) Due to (or as a consequence of):				-
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated				
ted Insit	Exar	events resulting in death) Last Due to (or as a consequence of): d.		_		
ie be executed ysician and burial - transit	edical	UNPENDED X AMENDED #20a-c,perFH,G9	e g916 6-24-11 11,1/20/2011,WS	vt		
3760 ificate the physical streets of the physical physica		IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth	death 3 Ectopic pregna		23d. Date of delivery Month D	eay Year
Box 6876 he death certificate the attending phy hed for use as the h	Physician/N	past 12 months? 4 Pregnant at time of death 5 Other	(Specify)		World: D	ay real
D. Be t the de- by the		Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tob	acco use contribute to t	he cause of death?
v requires that the speen signed by should be detach	d b			1 Yes	2 No 3 Proba	ably 4 Unknown
Records, The law require ficate has been si	Completed			24a. Was an autopsy	y prior to co	opsy findings available ompletion of cause of
Rec The la Tre la icate h				perform 1 Yes 2		s 2 No
Vital Reco	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient	26.Place of Death (Check		esidence 6 🗸 Other:	Scene
ling Phy After th funeral d	일	27. Manner of Death 28a. Date of Injury (Month Day Year) 28b. Time of Injury	ıry 28c. İnjury at Work?	28d. Describe ho	w injury occurred	doene
sion Attendia death. ctor: /	cation	2 Accident Investigation Dec. 2004 unk.	1 Yes 2 ✔ No		s. Motor Vehicle	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Certific	3 Suicide 6 Could not be determined (Specify) Major Road / Highway		or Town, Sta	reet and Number or Run ate) artin Boulevard, Esse	
To the Howithin 24 h Tn the Fur	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurre one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	n, in my opinion, death occurred a	t the time, date ar	nd place, and due to the	e cause(s)
	Σ	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (Moniting 2) January 2, 2011	th, Day, Year)
2V	İ	30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 900 W. Ba	altimore Street, Baltimore,	MD 21223		
St Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature				
HMH 17 Rev 1/20		JAN 20 2011 Server S. Jakes ORIGINAL			OCME	
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 4:41 am Wayne Bruce Hudson 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death the HOSPICE at omic 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🛛 M 2 🗌 F Days Jan 28, Year 1950 Director Maryland 216-56-2495 Usual Residence of Decedent show 10a. State 10b. County injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f MD Wicomico Hebron 1 Yes 2 X No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 25138 Rewastico Road 21830 USA permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1969 Black, White, etc 1 Never Married 2 Married þ Hvdson アゲック e Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates 1 Yes 2X No Specify: 1970 Specify Completed 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Elementary/Seconday (0-12) 12 life. DO NOT use retired) College (1-4 or 5+) carpenter construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Richard Eugene Hudson Edna Lee Adkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Lovett - sister 25138 Rewastico Rd; Hebron, Maryland 21830 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician. ORDPHARYN Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last the burial-trans attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2 s autopsy performe death? Yes 2[25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 1 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Manner of Death Certificate: Natural 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending in 24 hours are: the Funeral Director: After the Funeral Director and the funerated filled in by the funerated filled fi 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Pertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatur title of certifier

within 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Day, Year State Registrar's Sign 20 JAN Registrar **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2°6°11 January James David Hurley 4:15 ΑМ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Gilchrist Hospice Towson Baltimore 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Aug 27, 1936 1 🗓 M 2 🗆 F Days Min. North Carolina Director 218-34-7043 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12023 Eastern Ave 21220 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation Unk (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Mental Hygiene. larked other than College (1-4 or 5+) Elementary/Seconday (0-12) 10 automotive Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file.
Department of Health and Mental H
Important: If item 27 is marked ot.
any injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) Gilbert Harley Mary Iona Hurley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12023 Eastern Ave; Baltimore, MD 21220 Margarite Hurley - wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 X Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board Signature of Funeral Service Licensew and 655 W. Baltimore St; Baltimore, MD 21201 Part 1\Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finál Physician/ LUNG disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Dav Year 2 🗌 No s been signed by the should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform Division of Vital funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2 No ပ 4 ☐ Nursing Home 5 ☐ Residence 6 Other (Specify) Wor 2 W 1 Inpatient 2 ER/Outpatient 3 I 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: Natural 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 28c. Injury at 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the P within 2 29b. Signature D 58303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles ST MUN! Tauson MD 6701 Mories

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Joseph Waltman Heacock, Jr. January 18, 2011 6:56 A. ^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Lorien Mays Chapel Nursing Center Timonium Baltimore County 5. Social Security Number 6. Sex 1 M 2 □ F If Under 1 Year I If Under 24 Hrs 8 Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days (Month, Day, Months Hours Blenneim, MD. 220-34-7222 72 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland at Hygiene.

Jother than "natural", or items 23a or 28a-f sho or than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits Director Monkton Maryland Baltimore County 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14518 Jarrettsville Pike 21111-2410 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 11 Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married ğ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White If Yes Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Kansas City Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with. Department of Health and Mental Hygient Important: If item 27 is marked other the any injury or other traumatic. Life Insurance Co. Insurance Agent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဨ Joseph Waltman Heacock, Sr. Caroline Issenock 19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14518 Jarrettsville Pike Mrs.Pauline Mary(nee Cavanagh)Heacock Monkton, MD. 21111-2410 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State (Baltimore County) Date 1 \boxtimes Burial 2 \square Cremation 3 \square Removal from State cemetery, crematory or other place) Saturda Trinity Episcopal Ch.Cem. Jan. 22, 2011 4 ☐ Donation 5 ☐ Other (Specify) Long Green, Maryland 22. Name and Address of Facility Peace Full Alternatives Funeral & Cremation Center P.A. 2325 York Road Timonium, Waryland 21093-2215 21. Signature of Funeral Servige Licensee Joffrey L. Gair, Sr. hic. 於100677 Fat 1 Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) the attending physician and hed for use as the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day detached 9 I Hoknown g 🗌 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? an 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should een 24b. Were autopsy findings available 24a. Was an certificate has t autopsy prior to completion of cause of death? 1 ☐ Yes 2 No Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) l B examiner? Hospital Other: 1 Tes 힏 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Director: After this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 🗀 Pending injury 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours after To the Funeral Direc Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signa

State Registrar and address of person who completed cause of

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31. Date filed (Month, Day, Year)

N.

2

death (Item 23a) (Type, Print)

SIE

8/201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jan 17, 2011 Colemon E. Hill, Jr. 12:00p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A Baltimore St. Agnes Hospital 5. Social Security Number Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Funeral 1 🕶 M 2 🗆 F Months Davs Hours Director Virginia 212-52-4618 Jun 16, 1951 Usual Residence of Decedent Fshow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland notified at Director 23a or 28a-f 1 Yes 2 □ No Baltimore N/A Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral U.S.A. 21230 3126 Savoy Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black. White, etc. 1 Never Married 2 A Married þ 1 Yes : Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Specify: Black "natural" Completed Year or Dates of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Waste Water Management Operator 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ည Colemon E. Hill Sr. Margaret Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health i 3126 Savoy Street Baltimore, Maryland 21230 Jacqueline Hill 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit, Page 1 Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lansdowne, Maryland 01/22/11 Mt. Zion Cemetery 21. Sign alere of Funeral Service kicense 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21: 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Mysician/ 10 (disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transi Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Other (specify) Pregnant at time of death been signed by the a should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FXIOLIC Division of Vital Records, Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy has After this certificate 2 No 1 Yes 25. Was case referred to medica examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 **N**o ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 🔏 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔼 Natural injury 5 Pending work?
1 \(\subseteq \text{Yes} \quad 2 \subseteq \text{No.} \) _ Accident Investigation 24 hours after deat Funeral Director: filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year, 32. Registrar's State JAN 20 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month January 12:55 A.M Janice Marie Heying 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Linthicum Anne Arundel Tate Hospice House Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Hours 72 047027 1938 Marvland Director 217 34 3864 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director Maryland Anne Arundel Linthicum 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21090 402 Darlene Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian and Mental Hygiene. is marked other than "natural", or i 1 Never Married 2 Married Completed by 1 ☐ Yes 2 K No Specify: 3 ☐ Widowed 4 ☐ Divorced White Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) 3 years Page 1 and 2 should be filed within: ment of Health and Mental Hygiene. ant: If item 27 is marked other thar Elementary/Seconday (0-12) Registered Nurse Hospital years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Joseph Hackman Nina Alexandria Markoff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 402 Darlene Avenue Linthicum, Maryland 21090 Paul Heying / Husband Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State IJKN Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park Elkridge, Maryland 21. Signature of Funeral Service Lipensee 22. Name and Address of Facility Gonce Funeral Service, 4001 Ritchie Highway Baltimore, Maryland 21225 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: ဂ္ 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 5 Pending injury Accident 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature a 29c. License number D1828 30. Name and address of person who completed cause of death (Item 23a) Type, Print) 31. Date filed (Month, Day, Registrar's Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.) 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Physician/ CLARA C. JACOBS JAN 2011 7:19 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/AUNIVERSITY OF HARYLAND MEDICAL CENTER BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💆 F Min Hours 212 34 9269 74 67704/1936 Marvland Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Anne Arundel Severn 1 Yes 2 X No Maryland 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 7670 Old Telegraph Road 21144 U.S.A. death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Armed Forces . or Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 🗓 No ģ 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give "natural", 3 Widowed 4 Divorced Completed White Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Şeconday (0-12) College (1-4 or 5+) American Cleaners Clerk and Mental Hygie is marked other Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 George Cain Marie Berger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dawn Ponder / Daughter 5231 - 4th Street Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Baltimore, Maryland 01/19/2011 Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Int 1. Enter the diseas of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition SEPSIS 1 DAY Medical resulting in death) Due to (or as a consequence of): Examiner MRSA PNEUHONIA 2 WEEKS Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or iinjury Due to (or as a consequence of): Exami that the death certificate be executed physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending pl 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 5 Other (specify) Month Pregnant at time of death Dav Year 1 Yes 2 signed by the a d be detached f Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown GASTROINT ESTINAL BLEEDING Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an NON- ST ELEVATION HYDCARDIAL INFARCTION has autopsy performed? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director, **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 XNo Other: ည 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident work? 5 Pending Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

29b. Signature and title of certifier

DHMH 17 Rev 7/2009

Registrar

S. GREENE ST.

M.D.

2. Registrar's Sign

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22

GOLD BERG-

29c. License number

NPI 1346475191

BALTIMORE ND 21201

29d. Date signed (Month, Day, Year,

JAN 14 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Items 23aPtII,27,28a-f per me g921,11/01/2011dhb
Certificate of Death
Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month My 8:40 AM 20°7 David Charles Joy Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c County of Death Anne How Glen Burne If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. (Month, Day, Year) 11/08/1960 Hours Maryland 213 76 2712 50 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "marked other tha 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Glen Burnie 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21061 U.S.A. 8134 Phirne Road, East 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc þ 1 X Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Mt. Laney Roads Repair Paver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Charles W. Joy Mary Ann Schaeffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ann Joy / Mother 8134 Phirne Road, East Glen Burnie, Maryland 21061 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 01/18/2011 Baltimore, Maryland Holv Cross Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Gonce Funeral Service, P.A. 22. Name and Address of Facility 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or co shock, or heart failure. List only mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one chuse on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician/ Horom disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Education list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last to (or as a consequence of) ROVED BY MEDICAL EXAMIN Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month signed by the a 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by due to Soft Tissue Injury 1 Yes 2 No 3 Probably 4 Unknown cate has been signated by page 2 should by of Right Arm Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 X Yes 2 ☐ No Other: မ 1 Nnpatient 2 ER/Outpatient 3 DOA After this of funeral direction 4 \(\subseteq \text{Nursing Home} \) 5 \(\subseteq \text{Residence} \) 6 \(\subseteq \text{Other (Specify)} \) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work? 1 ☐ Yes 2 🗶 No 2 X Accident Natural Subject fell down stairs 01/10/2011 **Unknown**^M Investigation neral Director: / filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Unknown Friend's home within 24 hours a

To the Funeral C

completed filled Medical 1 Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certif 29d, Date signed (Month, Day, Year) D00327 who completed cause of death (Item 23a) (Type, Print) 301 GAV 31. Date filed (Mo 32. Registrar's S State Registrar

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nthony Kosowsi		State of Maryland / Department of Heat 1-For State Certificate of Deat Registrar			2 0 T	0 0 2 1
Physicia ledical Examir	ier	Alleliolly Rosowski		2. Date of Death Month January 11	Day Year , 2011	3. Time of Death 1153 hrs
			, Town, or Location of Death imore	1	4c. County of Deat	th
Funeral Director		<u> </u>	ider 1 Year If Under 24Hrs	_	C	irthplace (State or Foreign ountry)
	ŀ	Usual Residence of Decedent		7 4 7 7	2711	
Maryland 28a-f show any d at once,	ь	10a. State 10b. County 10c. City, Town or Location Baltimore				10d. Inside City Limits 1 X Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 10f. 2	(ip Code	10	g. Citizen of What Cou	untry?
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ter death w	Funeral	$\begin{array}{cccccccccccccccccccccccccccccccccccc$	cify Cuban, Mexican, Puerto		White, etc.	
ours af	d b	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usua	al Occupation (Give kind of		16b. Kind of Business	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f ahomatic event, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12)	orking life. DO NOT use ret ant	irea)	self em	ployed
21215-0036 Juld be filed within 7 Mental Hygiene, marked other than event, the Medica	Be	17. Father's Name (First, Middle, Last) unk	18.Mother's Name Nina Ko	sowski		
MD 21 ad 2 should lith and Me as 27 is ma aumatic en	유	No.	ss (Street and Number or 80th Ave; Cha			te, Zip Code)
두 모든 등 등	ŀ	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State crematory or other place.	ame of cemetery,	Date	20c. Location - City o	or Town, State
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		4 Donation 5 K Other Specify: in state Atlantic Crem	1-1	17-2011	Glen Burn	ie, MD
Balti permit. Departm Imports	ļ	21. Signature of Euneral Scryice Licensee Ronal S. Wade. Director	nd Address Facility Ct City Cremati	on & Fun	eral Servi	ces ₂₀₁
Physician	T	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mod failure. List only one cause on each line.	e of dying, such as cardiac	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a Congestive Heart Failure Due to (or as a consequence of):				Death
		Sequentially list conditions, b				
	Examiner	if any, leading to immediate Due to (or as a consequence of): Quisease or injury that initiated Due to (or as a consequence of): Quisease or injury that initiated				
ecuted and - transit	Exa	events resulting in death) Last Due to (or as a consequence of): d.		*		
ĕ = = I	edical	☐ UNPENDED X AMENDED #20a-c,22perFH,G91	1,1/20/2011,	WS		
ox 68760, ant certificate be ex attending physician or use as the burial	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dear	. 🗀 .		23d. Date of delive Month	ery Day Year
SOX (death or e attence for use	ysici	4 Pregnant at time of death 5 Other (S) 1 Yes 2 No 9 Unknown	pecify)			
D. Hat the ed by the etached	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying	ing cause given in Part I.		bacco use contribute t	
rds, P.C requires that been signed hould be deta	ted b	Diabetes mellitus, morbid obesity		1 Yes		obably 4 Unknown
S law	Completed			autop: perfor	sy prior to med? death?	completion of cause of
ital Recicion: The certificate rector, page	æ	25. Was case referred to medical examiner?	26.Place of Death (Check			
ing Physique Thirach	<u>۽</u>	1 V Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	DOA Other Nursi 28c. Injury at Work?		Residence 6 🗹 Oth	er: Scene
ion (trending leath.	ation	1 V Natural 5 Pending 2 Accident Investigation (Month, Day, Year)	1 Yes 2 No			
Divis	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factor (Specify)	ory, office building, etc.	28f. Location (S or Town, S		Rural Route Number, City
To the Hospital within 24 hours To the Funeral completely filled	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at one) 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.				
) F 3 F 3	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (M	
4		(Carrent	O.C.M.E.		January 13, 20	11
		30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 900 W. Baltimo	ore Street, Baltimore,	MD 21223		
		31 Datesfiled (Month, Pay Veer) 32 Registrat's Signature				

DHMH 17 Rev 1/2001 OCME 2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per ANA BD G912 2/09/2011 JH. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Lillian Bertha Kenny 6:15 A M 10 2011 anuar /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Arnold Anne Arundel Future Care - Chesapeake If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. Min.) 8. Date of Birth (Month, Day Ye March 10, 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Year) 1929 Months 1 □ M 2 🕅 F Maryland Director 81 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, The Madical Examination and be notified at MD Anne Arundel Severna Park 1 ☐ Yes 2 No Directo death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21146 USA 607 Lakeland Road South Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: if them 27 is marked other them any injury or other trainment. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2K Married white If Yes, Give Year or Dates: 1 ☐ Yes 2 K No Specify: 3 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) day care provider nursery school 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marie Flynn George Meisenhalder 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Kenny - husband 607 Lakeland Road South; Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4⊠Donation 5 ☐Other (Specify) Ron 1 S 22. Name and Address of Facility State Anatomy Board Director Wade 655 W. Baltimore St; Baltimore, Maryland 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** END STAGE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): physician at the burial P.O. Box 68760, Physician/Medical ending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery atter for u 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) been signed by the should be detached to 1 □Yes 2 No 9 Unknown 9 Unknowń Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s has autopsy performed? 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10, 75 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Veterans 204 661 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6145 Month CNIGH TA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Tate Hospice House Linthicum 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🗷 F Months Days Hours Min 213 26 2884 80 Yrs Director MD Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at **Funeral Director** Crownsville 1 Yes 2 X No MD Anne Arundel 10e Street and Number 5 10f. Zip Code 10g. Citizen of What Country? items 23a 21032 U.S.A. 989 Round Bay Road filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ö þ 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify Specify. "natural" Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Naval Academy 11 Cashier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Gladys Roth Henry Mahn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is any injury or other trau once. 5716 Richardson Mews Sq. Baltimore, MD21227 Sheila Goins - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗎 Removal from State Glen Haven Mem Pk | 1/19/11 |Glen Burnie, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility GJ Gonce Funeral Home, 21. Signature of Euneral Service Licensee 21122 169 Riviera Drive Pasadena, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) physician a Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an nas e 2 performed? Yes 2 N 2 🗆 No 1 TYes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: HUSPICE ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of HUUST Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 Yes 2 No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined 24 hours a 29a, Certifier 🕊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number

Registrar

DHMH 17 Rev 7/2009

State

Name and address of person who con

Day, Year)

MICHAEL

31. Date filed (Month,

445

DEFENSE

MO21401

Jewy W Jeause of death (Item 23a) (Type, Print)

ENM

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 7:35 PM Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** MD HOSPITAL SAMARI TAN If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** MOG! Months Country) Director City, Town or Location 10d. Inside City Limits or 28a-f show 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once. Directo Yes 2 □ No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Ccountant Be 18. Mother's Name (First, Middle, Maider 17. Father's Name (First, Middle, Last) ဥ terbe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City Mother Dalty 20b. Place of Disposition (Name of cemetery, crematory of other p 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22/ Name and Address of Facility Maryland 21213 -MO155 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and D at Immediate Cause (Final FRITONITIS Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner MONAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury been signed by the attending physician and should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DIABETES MELLITUS 2 No 3 Probably 4 Unknown 1 Yes After this certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an YTOPENIC. autopsy performed Yes 2 death? CHRONIC 2 🗌 No HEPATITIS 1 Yes KIDNEY DISEAS 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) the funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ρ 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28f, Location (Street and Number or Rural Route Number, Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide City or Town, State) Hospital Medical Ecritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d, Date signed (Month, Day, Year) 29b. Signature and title of certif 29c. License number M.D 000 RES 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MD 21239 GOOD SAMARITAN HOSPITAL, 5601 LOCH RAVEN BLVD BANSAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Vivian D. Lyon 15 Jan. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2🏋 F Months Davs Hours 08-19-1928 North Carolina 240-38-3844 82 Director Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ld be filed within 72 hours after death with the Maryland Mental Hygiene. Director DC Washington 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 42 53rd Pl. SE 20019 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Bace - American Indian Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rlack. White, etc. 1 Never Married 2 Married ò Yes 2 XNo Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: If Yes, Give 3X Widowed 4 ☐ Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 7 h and Mental Hygiene. 7 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Navy Annex Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Marion Daniels Alazada Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st.
Department of Health ar
Important: If item 27 is
any injury or other trau Jennifer Wimbish/Daughter 6710 Hastings Dr. Capitol Heights, MD 20743 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State Ft. Lincoln Cemetery 01-24-2011 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service License 22. Name and Address of FacilityRonald Taylor II FH 10583 Middleport Ln. White Plains, MD 20695 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death)) Medical Examiner Due to (or as a consequence of) hvohi Sequentially list conditions Examine if any leading to immedicause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month Day 5 Other (specify) Year signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available 24a Was an page 2 s prior to completion of cause of death? autopsy performed this certificate 2 No 1 Yes 25. Was case referred to medica director Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral Manner of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending Accident 1 Yes 2 No Investigation within 24 hours after deatl

To the Funeral Director;

completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Toertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertliving Number Practice of Talke of the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and yind 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0060100

Registrar
DHMH 17 Rev 7/2009

State

A Hmins

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

31. Date filed (Month, Day, Year)

		1- For State Registrar	ertificate of	of Death			Reg. No.	الكاسا	0102
Physici		Decedent's Name (First, Middle,Last)				2. Date of De Month		Year	3. Time of Death
Medical Exami	ner #	Russell 4a. Facility Name (if not institution, give street and number)	Willia		is or Location of Deat	Month January		County of Death	0450 hrs
		Intersection of I-695, Eastbound & Providence	Road	Towson	5, 20044,0.1 0, 2044			Itimore Cou	
Funeral		5. Social Security Number 6. Sex 7. Age (In yr.	s. last birthday)	If Under 1 Ye		_	Birth (MM/DE		thplace (State or
Director		217-84-4906 1XM 2 F	39 Y	frs. Months Da	ys Hours Min	n. 7-27	7-197	T Foreig	untry) MD
ÿ		Usual Residence of Decedent	ity, Town or Loc	eation					10d. Inside City Lin
d anow any			altimon						1 X Yes 2
arylan 8a-f sl	Director	10e. Street and Number		10f. Zip Code	-		10g. Citize	n of What Cour	ntry?
rith the Maryland 123a or 28a-f show a notified at once.		5130 Hillburn Avenue		21	206			USA	
n with	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces?			lispanic Origin? (S an, Mexican, Puert		No- 14	4. Race - Ameri White, etc.	can Indian, Black,
or ite	Fun	1 Yes 2 X No	_	- VII.		o radan, oto.)			Black
irs afte	by	Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)		Yes 2 X N lent's Usual Occup	o <i>specity:</i> ation (Give kind of	work done		pecify: nd of Business/I	ndustry
72 hou	etec	Elementary/Secondary (0-12) College (1-4 or 5+)		most of working lif	e. DO NOT use re	tired)	1		
5-0036 led within 7 Hygiene. lother than the Medica	Completed	12th grade					*		rucking
filed v		17. Father's Name (First, Middle, Last) Sylvester Lewis, Sr			18.Mother's Nam	e (First, Middle ne Ros		ırname)	
2121 ould be fil Mental I marked	To Be	DYLVEDCEL	19b. Mail	ing Address (Stre	eet and Number or			or Town, State	, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	_	19a Informant's Name/Relationship (Type, Print) Mitchell Darlene R. Johnson-Mother	27:	36 Harl	em Aven	ue Bal	Lto,	MD 21:	216
re, land f. Heal		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	b. Place of Disponental by the base of the	osition (Name of cother place)	emetery,	Date	20c. Lo	cation - City or	Town, State
Baltimore, Department of He Important: L'ite	-	4 Donation 5 Other Specify:	Greenmo	ount	1-	13201			MD 2120
Salt ermit. Depart mport njury		21. Signature of Imeral Service Licenses		Name and Addre		March		st F/F	
		23a. Part I. Foter the disease, or complications that caused the dea			North A			to,MD	Approximate Inte
Physician Medical		failure. List only one cause on each line.							Between Onset a Death
kaminer		Immediate Cause (Final disease or condition resulting in death) a. Smoke Innal: Due to (or as a consequence)		nd merma	it injuit	.es			
	Ļ	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence	f\:						
	raminer	Cisease or injury that initiated	3 OI J.						
ed nsit		events resulting in death) Last Due to (or as a consequence	∍ of):						
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60, ate be ohysici	Med	IF FEMALE: 23c. If yes, outcome of pr		2-28-11	vt zac pe	r me g		-2-11 v1 Date of delivery	
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of V g Phys rer this eral di	<u>۱.</u>	1 Yes 2 No No Inpatient 2 2 27. Manner of Death 28a. Date of Injury	ER/Outpaties 28b. Time of		ury at Work?	28d. Describ	e how injury	occurred S1	ubiect
Division of Vii pital or Attending Physic ours after death seral Director: After this filled in by the funeral dir	tion	Natural 5 Pending (Month, Day Year)	fd 4:3	36am 1X	Yes 2 No	trucke	er inv	olved :	in motor and fire
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physicic completely filled in by the funeral director, page 2 should be detached for use as the buri		29a. Certifier (Check only one) Certifying Physician: To the best of my knowled one) Medical Examiner: On the basis of examination	-						
To t Withi To tl	Medical	and manner stated. 29b. Signature and title of certifier		1271	se number	, 20		ite signed (Mor	
		TII MIT	TI		.M.E. OCM	Ē		ary 4, 2011	
11		30. Name and address of person who completed cause of teath (Ite	em 23a)	1/.					
0		Theodore M. King, Jr., MD. Assistant Medica	l Examiner	900 W. Balti	more Street, E	Baltimore, N	1D 21223	3	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20a-c&22 Per FH G911 1/19/2011 JH State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ _Month January Peter Steven Lubezny 11:40 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Feb 12, Year 956 1 🖾 M 2 🗆 F Months Days Hours Min Illinois Director 342-16-9733 54 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🖾 No Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21701 312 W. Patrick St; Apt A 12. Was Decedent Ever in U.S. . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify: white If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) disabled none 10 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Marion Panko Steven Lubezny 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Rurka 2555 Hawthorne Ave; West Chester, Illinois 60154 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial XX Cremation 3 Removal from State Final Journey Crem. 1/18/2011 Woodbine .MD 4 ☐ Donation 5 Di Other (Specify) in state 21. Signature of Fund Service Licensee Ronald S. Wade Name and Address of Facility to the Process P. A. C. C. Baltimore St. Baltimore P. M. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Priysician disease or condition resulting in death) Medical Due to (or as a consequence f) Examiner Sequentially list conditions, if any, Isading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine as a consequence of the attending physician and hed for use as the bunal-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 1 ☐ Yes ∠ 2 9 ☐ Unknown page 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 certificate has 1 ☐ Yes 2 ☐ No 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Malinpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After Natural 5 Pending work? 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 1 📐 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated
Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated
Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 To the F only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Wine n. -2011 of death (Item 23a) (Type, Print) Name and address of person who completed caus 32. Registran's Sig State Registrar

			For State o	f Maryland / I	Department of Healt Certificate of Deat	th	iene eg. No. 2011	01028
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and 2	/Medic	al	Nellie 4a. Facility Name (If not institution, give street and nu	Irene Lew	4b. City, Town, or Locati	Janua (4 County of Death	1:25PM
	Funeral Director	GI	5. Social Security Number 233 34 5462 1 M 2 T F	7. Age (In yrs. last bi	Cator	nder 24 Hrs. 8. Date of Birth	9. Birth	more place (State or Foreign intry) St Virginia
	ס		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	n or Location			10d. Inside City Limits
	Maryli a-f sho	żo	Maryland Baltimore		onsville			1 ☐Yes 2 X No
	or 28	Director	10e. Street and Number	100	10f. Zip Code		0g. Citizen of What Cou	untry?
	ms 23a	Funeral	713 Maiden Choice Lane	edent Ever in U.S.	9 21228 13. Was Decedent of Hispanic If Yes, specify Cuban, Mex		U.S.A.	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modeal Eventher mast be notified at	by	1 □ Never Married 2 □ Married 1 □ Yes, Gi 3 ☑ Widowed 4 □ Divorced	2 X No ve ates:	1 □Yes 2 No Spec	ecify:		nite
15-	in 72 h 	plete	15. Decedent's Education (Specify only highest grade completed)		 Decedent's Usual Occupation (Give kind of work done during r life. DO NOT use retired) 	most of working	16b. Kind of Business/Ir	
212	filed within Hygiene.	Completed		ears	Teacher		<u> </u>	Education
Maryland	2 should be file and Mental H Is marked oth aumatic even	To Be	17. Father's Name (First, Middle, Last) Arlie V	V. Keister	18. M	Mother's Name (First, Middle, M Goldie E. S	,	
	1 and 2 show Health and Mem 27 Is ma		19a. Informant's Name/Relationship (Type. Print) Robert Lewis II / Son		b. Mailing Address (Street and Nu 09 W. 11th Aven		, City or Town, State, Z imore, Mary	
Baltimore,	g = 5		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	Siale	of Disposition (Name of ery, crematory or other place) wridge Mem. Parl	k 01/21/2011	20c. Location - City or TElkridge,	Maryland
Ball	permit. Pag Departmen Important: any injury once.		21. Signature of Funeral Service Licensee	rouski	22. Name and Address of Fa 4001 Ritchie	^{Facility} Gonce Fune Highway Balt	eral Service cimore, Mar	e, P.A. yland 21225
10	Physician		23a Part 1. Enter the disease, or complications that a shock, or heart failure. List only one cause on a limmediate Cause (Final disease or condition resulting in death)	aused the death. Do		ch as cardiac or respiratory arr	est,	Approximate Interval Between Onset and Death
أم	/Medical Examiner		Due to	(or as a consequence				
	uted I nnsit	Examiner	cause. Enter Underlying Cause (Disease or injury	(or as a consequence	of):			
,00	ficate be execute physician and the burial-trans	Exal	that initiated events .	(or as a consequence	of):			
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Vita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?		Othor	Place of Death (Check only on		
of	Physer this eral dir	. To	27. Manner of Death 28a. Date		Time of 28c. Injury at	Nursing Home 5 ☐ Reside	ence 6 Other (Spec	cify)
sion	or Attending Physician: after death. Director: After this certifica in by the funeral director, p	ation	2 Accident investigation	th, Day, Year)	Injury Work? M 1 □Yes		,	
Division	tal or Attendi s after death. al Director: A ed in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place build	e of Injury - At home, f ing, etc. <i>(Specify)</i>	arm, street, factory, office	28f. Location (S. City or Town	treet and Number or Ru n, State)	ıral Route Number,
	To the Hospital or I within 24 hours after To the Funeral Directorpletely filled in b	Medical ((Check only 2 Medical Examiner: On the b	e best of my knowledgesis of examination and stated.	ge, death occurred at the time, da and/or investigation, in my opinion.	ate and place, and due to the on, death occurred at the time, o	ause(s) and manner as late and place, and due	s stated. to the cause(s)
	North Com	Σ	29b. Signature and title of certifier	MD	29c. License numb		Sanuary	
1	0		30. Name and address of berson who completed cau	,711 Ma	(Type, Print)	Lane Balt	January impre, MD	> 21228
	Sta Registr		31. Date filed (Month, Day, Year) 32. F	Registrar's Signature	hard	/	,	
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Amend 10a-c, 10 state of Mar Van 69 16 e 6/15/11 of Thealth and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Stancil 0347 AM Lively 201 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Date of Billing (Month, Day, Yea V 21 1 🗆 M 2 🗆 F Months Hours Director 219-40-4889 64 MD Usual Residence of Decedent 28a-f show 10a. State DC th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location be filed within 72 hours after death with the Maryland Washington 10d. Inside City Limits Director Baltimoro 1X Yes 2 No 10e. Street and Number 2521-12th Street, NW 10f. Zip Code 20009 10g. Citizen of What Country? Funeral USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify. Specify: Black %☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 4 College (1-4 or 5+) Elementary/Seconday (0-12) Producer NBC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Macauley Stancil Irma Barnhill permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Malik Lively 2411 W. Rogers Ave. Balto, Md. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pla cemetery, crematory or other place) Jan 20,231
Green Mount Crematory 1 Burial 2 Cremation 3 Removal from Sta Balto, Md 4 ☐ Ponation 5 ☐ Other (Specify) Mounture of Funeral Service Licenses allvin B. Scruggs Funeral Home Preston St. Balto, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Non-ischemic disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): sate has been signed by the attending physician page 2 should be detached for use as the burial ω Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No Day Pregnant at time of death Month Year 5 Other (specify) 9 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Nown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No this certificate 1 Yes 2 No To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical B 26. Place of Death (Check only one) examiner? 2 No Certificate: To 1 npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital within 24 hours a To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier AU41764356 19756 30. Name and address of person was completed cause of death (Item 23a) (Type, Print) Sough 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JAN 2 0 2011

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ORIGINAL

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		For State Registrar	State of Maryland	•	artment of tificate of		nd M	, ,	giene Reg. No.2	011	01030
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Medi	cal		ller					Tanuan	118,	9011	6:15 PM
Examir	1er	4a. Facility Name (if not institution, give single Union Memorial Ho			4b. City, Town, Balti		Death			nty of Death	re City
Funeral		Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Yea	If Under 2		8. Date of Birt	h	9. Birtl	nplace (State or Foreign
Director		216-42-6011	^{1M2□F} 65	Yrs.	Months Day	s Hours	Min.	(Month, Day 01/03/	, Year) 1946	Mar	yland
ld now	۰	Usual Residence of Decedent 10a. State 10b. County	10c City	, Town or Lo	cation						10d. Inside City Limits
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he Mi or 28	ä	10e. Street and Number	idel do.	.II CII I C	10f. Zip Code				10g. Citizen	of What Cou	
nd 21215-0036 filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at	Funeral Director	406 Nancy Avenue		21090					_	ed Sta	
death items		11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	. 13.\	Was Decedent of f Yes, specify Cu	Hispanic Origi	in? (Speci	ify Yes or No-		Race - Amer	
after after kamir	l by	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ No If Yes, Give		l ☐ Yes 2 🗓 N		T GOILO II	10011, 010.7	Spec	Black, White	
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withii vgiene rate the table		Licinomasy Occorday (5-12)	2	Pol:	ice Offi	.cer			Lav	v Enfo	rcement
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ore, Maryland 21215-0036 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. I item 27 is marked other than "natural", or other traumatic event, the Medical Exam		19a. Informant's Name/Relationship (Typ	e, Print)	l .	ng Address (Stree Nancy A			Route Numbe n thicu n	•	n, State, Zip 21090	
Te, 1 and f Heal item		Mrs. Linda Miller 20a. Method of Disposition		ace of Dispo	sition (Name of	!		ate	20c. Locatio		
imor Page 1 nent of ant: If it ury or o		1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)			natory or other p. ark Ceme		1221	2011	Baltin	nore.	Maryland
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or other once.		21. Signature of Funeral Service Ligense		22	2. Name and Add	ress of Facility	Sin	gleton	Funera	a1 & C	Cremation
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Medical Examiner		resulting in death)	Due to (or 's a comequ	ence on:		Α		7			
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ		ellitu	.5 1	746	2 1		_	
ansit de d	Examine	cause. Enter Underlying Cause (Disease or linjury that initiated events	Cardiac	A	vres1	+				1	
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0 50	Physician/Medical		l								
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the de sched	hysi	1 Yes 2 No 9 Unknown	9 Unknown								
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dS, quires en sig ould b	ted				<u> </u>			1 🗆 '	Yes 2 □ N	o 3 \square Pr	obably 4 Unknown
DIVISION OF VITAI HECONGS, tal or Attending Physician: The law requires its after death. al Director: After this certificate has been signed in by the funeral director, page 2 should be an income.	Completed	-						24a. Was autor		lb. Were aut	opsy findings available completion of cause of
The I	S							perfo	rmed? 2 No	death?	2 🗆 No
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Phys Phys	일 :	1 ☐ Yes 2 ☑ No ☐ 27. Manner of Death	1 ☐ Inpatient 2 ☐	ER/Outpatier 28b. Time of	nt 3 🗆 DOA	4 Nur	sing Hom	ne 5 Resid	lence 6 0	Other (Speci	wunion memorial
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Atter er dez ector by th	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)		eet, factory, offic	e	2			mber or Run	al Route Number,
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DIVISION Of VITAI RECORDS, P.O. BOX 68/05 To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phycompleted filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 Me Lat Examin	cian: To the best of my knowledger: On the basis of examination	and/or inves	tigation, in my opi	inion, death occ	curred at t	he time, date a	nd place, and	due to the c	ause(s) and manner stated.
o the vithin o the comple	Σ	29b. Signature and title of certifier	Practioner: To the best of my	knowledge,		nse number	and plans		29d. Date sig		
->-		> / Our	~ , mp		DC	0066	212		Januar		
110		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, F							·
101			mpleted cause of death (Item 201 East Univer	sity Pa	rkway, f	3aHimo	re, m	varylan	d 219	418	
Sta Registr		31. Date filed (Month, Day, Year) JAN 2 0 2011	32. Registrar's Signati					1			
DHMH 17 Rev 7/2	_	JUN 211 2011	D. A.	Erkal							
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DHMH 17 Rev 7/2009

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State of Maryland / Department of Health and Mental Hydiene

			1 - State Registrar	State of Marylan		tificate of E		, ,	gierie _{Reg. No.} 2 (01031
П	Physicia	ın/	1. Decedent's Name <i>(First, Middle, Last)</i> Grace Markey		_	<u>-</u>		Date of Dea Month	Day	Year	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give s	reet and number)		4b City Town or	Location of Death	January			7:59 A M
~	LXaiiiii	GI	Gilchrist Hospice	,			Towson			4c. County of Death Baltimore County	
	Funeral Director		5. Social Security Number 214–14–5140 Usual Residence of Decedent	7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		8. Date of Birth O_12_1914		place (State or Foreign try) ryland
	Maryland 8a-f show tifled at	rector	10a. State 10b. County Maryland Harford	,	r, Town or Loc	ation 11ston				0d. Inside City Limits 1 ☐ Yes 2XX No	
	h with the l ns 23a or 2 nust be no	Funeral Director	10e. Street and Number 3433 Widows Care			10f. Zip Code 21	1047		10g. Citizen of	What Coun	*
336	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ance.	d by Fu	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	 2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 	lf	Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)		ce - Americack, White, e	etc.
2-0	2 hours "natur dical E	plete	15. Decedent's Edu (Specify only highest grad	cation		ent's Usual Occupa				white d of Business Industry	
Baltimore, Maryland 21215-0036	within 72 rgiene. ner than '	Completed by	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. DC	kind of work done during most of working O NOT use retired) Reads De			epartme	ent Store	
and	oe filed Intal Hy ked otf	To Be	17. Father's Name (First, Middle, Last) Michele Dinunzio				18. Mother's Name (First, Middle, Maiden : Anna Saunders			ne)	
ary	and Me		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Maifin	g Address (Street a	nd Number or Rura			State, Zip C	Code)
Σ	nd 2 st ealth a m 27 is			Daughter		Widows Care		n, Maryla	-	, , , ,	
more	Page 1 a nent of H ant; If ite iry or oth		20a. Method of Disposition 1 By Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	emoval from State	emetery, crem	of Disposition (Name of ery, crematory or other place) Date 20c. Location - Cite and Partial Partitions Date 20c. Location - Cite and Partitions Partitional Cemetery 1/21/2011 Baltimore				-	
Balti	permit. Departn Importa any inju		21. Signature Funera dervice Dicenser		22.	Name and Address				24.4	a y acord
	Physician/) Medical Examiner	er	23a Part 1 Enter the disease, of complishook, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any keeling to immediate	cations that caused the death cause on each line. Due to (or as a consequence)	. Do not ente	r the mode of dying	, such as cardiac o	r respiratory arre	est,		Approximate Interval Between Onset and Death
094	death certificate be executed re attending physician and ed for use as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a consequent	ence of):	ciky	Acc	iden	X	1	
P.O. Box 687	death certifi ne attending ed for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	ic. If yes, outcome of pregnar 1 Live Birth 2 Fetal 4 Pregnant at time of do 9 Unknown	death 3	Ectopic pregnancy Other (specify)	/			ate of delive	ery Day Year
ds, P.O	s tha	by	Part II. Other significant conditions con	ributing to death but not resu	Ilting in the ur	nderlying cause give	en in Part I.				e cause of death?
Division of Vital Records,	sician: The law rec certificate has be lirector, page 2 sho	Completed						24a. Was a autops perfor 1 \(\subseteq \text{ Yes} \)	sy med?		osy findings available impletion of cause of
ita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner? 1 Yes 2 No	espital:		Othor	ce of Death (Check	, ,		\	+ 12 + 20 m
on of V	nding Physath. ath. ': After this e funeral di	icate: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	1 Inpatient 2 Is 28a. Date of injury (Month, Day, Year)	ER/Outpatient 28b. Time of injury	28c. Injury work?	4 ☐ Nursing Horat	ne 5 Reside			the state
Division	spital or Attendir lours after death. eral Director: Af filled in by the fu	l Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, stree	et, factory, office		28f. Location (St City or Town		per or Rural	Route Number,
	To the Hospital within 24 hours: To the Funeral I completed filled	Medical	(Check 2 ☐ Medical Examine only one) 3 ☐ Certifying Nurse	ian: To the best of my knowle r: On the basis of examination Practioner: To the best of my	and/or investi	gation, in my opinior	n, death occurred at	the time, date an	nd place, and du	ue to the cau	se(s) and manner stated.
	To t		29b. Signature and title of certifier	0		29c. License		l l	29d. Date signe	ed (Month, D	Day, Year)
	1		30. Name and address of person who con	1	23 a) /Tue = D	int) A	25808 E Leu		1/12	7/5	110
	QV		WAOIN WE CAN	r Les A	zoaj (type, Pr	Int) Arra	· Bult	S CO	2 M	one Dis	eva, CRM
	Stat Registra		31. Date filed (Month, Day, Year) JAN 2 0 2011	2. Registrar's Signatu	Land	W		- 444-4	, , 1		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 1 13 **Physician** Martha B. Moore ам 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Future Care Northpoint Baltimore na Date of Birth (Month, Day, Year) 2-12-1921 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 😿 F Months Days Hours Min. 212-16-5904 S.C. 89 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 7 is merked other than "natural", or items 23a or 28a-f show treumetic event, the Medical Examble must be mortified at 1 XYes 2 ☐ No Director Baltimore MD na death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21213 3814 Sinclair Lane USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural" ~ any injury or other treumetic ever 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Black 2 Specify: 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Homes Domestic Worker 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sarah Brown George Muldrow ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3814 Sinclair Lane Balto, MD 21213 McKever Brown-Nephew 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State King Memorial Pk 1-19-2011 Randallstown, MD 22. Name and Address of Facility March East F/H 21. Signature of Fuperal Service Licensee Balto, MD 21202 1101 E. North Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MITTEROSCUENOTIC TROIDVATEUUM disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed aftending physician and for use as the burlal-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d, Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has autopsy performed certificate 1 ☐ Yes 2 To the Hospitel or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b./Signature D0060560 18,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PANKA KHETERMAL 9106, PHILADELPHIA

State

Registrar

31. Date filed (Month, Day, Year)

JAN 2 0 2011

2. Registrar's Signature

	1	For State Registrar		State of M	laryland	-	irtment of <i>tificate of</i>		d Mental Hy	/giene Reg. No.	2011	01033
Physiciar /Medica		1. Decedent's name (F	First, Middle, Last)	d	/	Mac	CK		2. Date of D Month	eath Day	~ 2 Year	3. Time of Death
Examine		4a. Facility Name (If no			·)		Balt	or Location of De		4c. 0	County of Death	
Funeral Director		5. Social Security Num 217 40 Usual Residence of De	6. Sex	M 2□F 7.A	ge (In yrs. la	est birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi	in. (Month, D	irth Pay, <i>Year)</i> 4–19	Cou	place (State or Foreign ntry)
e Maryland la-f show	Director		na a	1		Town or Lo						10d. Inside City Limits 11 Y Yes 2 □ No
after death with the Man or items 23a or 28a-f st miner must be notified	rai Dire	10e. Street and Number		l Road			10f. Zip Code 2123	19			en of What Cou	ntry?
ST		11. Marital Status 1 ↑ Never Married 3 ○ Widowed 4	2☐ Married	Was Decedent Armed Forces' 1 Yes 2 ☐ If Yes, Give Year or Dates:	? No		Vas Decedent of fYes, specify Cul I∐Yes 🎎 No	oan, Mexican, Pu	(Specify Yes or N erto Rican, etc.)		4. Race - Ameri Black, White, Specify: B	
be filed within 72 ho tital Hygiene. d other than "natu event, the Medical	Completed	15 (Specify Elementary/Seconda		ation completed) College (1-4or	5+)	(Give life. L	dent's Usual Occu kind of work done DO NOT use retir Painter	during most of wed)	vorking	ľ	od of Business/Ir	
2 should be filed within and Mental Hygiene. is marked other than aumatic event, the Mental Hygiene.	lo Be	17. Father's Name (Fin.	st, Middle, Last)	_				1	lame (First, Middle e Mae		Surname)	dately
permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic every process.		19a. Informant's Name Daylene 20a. Method of Dispos	Anders	,		15		et and Number or	Rural Route Num Road Date	Balt	Town, State, Zi	21239
mit. Pages vartment of cortant: If It injury or o			Cremation 3 ☐ Re ☐ Other (Specify)	<u></u>	_ ce	riso	n Fores	st 1-	18-2011	Owi	-	lls, MD
B D De I		23a. F. m. Enter III-shock or heart fa	mello isease, or complicallure. List only on	rations that cause	ed the death				Avenue diac or respiratory		o, MD	21202 Approximate Interval Between
Physician /Medical Examiner		Immediate Cause (Fin disease or condition resulting in death)		Pros	tat s a consequ	ence of):	mur	- Will	1 Bornetas	ne Fast	21	Onset and Death
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.											
eath certific attending p for use as	sician/ive	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ecto 4 □ Pregnant at time of death 5 □ Othe						c pregnancy 23d. Date of delivery Month Day				,
w requires that the d	red by Pnys	Part II. Other significa	int conditions con	tributing to death	but not resu	Iting in the un	nderlying cause g	iven in Part I.		tobacco us	se contribute to	the cause of death?
ician: The law r certificate has b ector, page 2 sh	Completed	OF W.	0'	0		-			per 1 □ Yes	opsy formed? 2	prior to c death?	opsy findings available ompletion of cause of
g: S	tion: to be	25. Was case referred examiner? 1 Yes 2 No 27. Manner of Death 1 Natural		ospital: 1 Inpat	iury	ER/Outpatier 28b. Time of Injury	28c. Inj	ther: Nursin	Death (Check only g Home 5 ☐ Re 28d. Describe	sidence 6		ify)
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 4 ☐ Homicide	Could not be determined	building, e	etc. (Specify	")	eet, factory, office		City or T	own, State)		ral Route Number,
the Hospi thin 24 hou the Funer mpletely fill	Medical	29a. Certifier (Check only one) 29b. Signature and title	Certifying Phys	ician: To the bes er: On the basis and manner s	of examinat	vledge, deat ion and/or in	vestigation, in my	time, date and pl	ace, and due to the courred at the time	e, date and	place, and due	to the cause(s)
P\$P\$	-	30. Name and address	ilm	MD	death /Hom	220) /Time			7/		e signed (Month	2011 Le M/2123
State	9	M· K 31. Date filed (Month,	HAN,	mpleted cause of 560	1-	LOC parke	LRO	ven 1	15/vd,	Bo	altimo	W M/212
Registra OHMH 17 Rev 1/200		JAN 2	U ZUIT ,	Lieun	P. 1	parke						

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VOID

CERTIFICATE

2011 - 01034

SEE

CERTIFICATE

2010 - 43194

1 - For State Registrar

Physician /Medical

1. Decedent's Name (First, Middle, Last)
Thomas Benjamin Miller

Examiner		4a. Facility Name (If not institution, give street and number) Fort Washington Hospital			4b. City, Town, or Location of Death Ft Washington			4c. County of Death Prince George's	
Funeral Director		41111110111	ex TMM 2□ F 7. Age (In yrs 8.9	: last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	У°17921 9. Е	Birthplace (State or Foreign Country) KY
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar mast be natified at once.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limi							10d. Inside City Limits
	tor	MD P.G.	Fo	ort Wa	shingto	n			1 □Yes 2 X No
	Funeral Director	10e. Street and Number 12012 Nevin Lane			10f. Zip Code 20744			og. Citizen of What Country? USA	
	þ	11. Marital Status 1 Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U. Armed Forces? 1 Married Forces?			S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes ※*No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black	
	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	16a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retire	pation during most of worki	ing 1	6b. Kind of Busines	ss/Industry
	Som	Elementary/Secondary (0-12)	College (1-4or 5+)			oning Er	gineer		enance
	To Be (January 17. Father's Name (First, Middle, Last) George Benjamin Miller				18. Mother's Name (First, Middle, Maiden Surname) Unavailable			
		19a. Informant's Name/Relationship (Type. Print) Daughter			t and Number or Rura Lane F1			
		20a. Method of Disposition 1 ☐ Burial 2 【A Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removal from State 20b.		osition (Name of matory or other pla C Crem	i	3/11	Oc. Location - City Glen Bu	cnie
permit. Depart Import any Inj once.		21. Signature of Toperal Service Licer	4/h	ı T	2. Name and Address Al	ess of Facility Sin lenPA 70	Bbigit	y Cremat ge RD Ha	tion & Fun anover MD
Physician		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line			_		st,	Approximate Interval Between Onset and Death
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Onset and Death Onset and Death Onset and Death							
that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence of):						
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c						
		resulting in death) Last	Due to (or as a conse	quence of):					
	Physician/Medical	ISSEMILE.							
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	☐ Ectopic pregnan☐ Other <i>(specify)</i> _			23d. Date of Month	delivery Day Year
s that I	_	Part II. Other significant conditions				ven in Part I.	23e. Did tob	acco use contribute	e to the cause of death?
equire een sig ould b	ted by	feeding dystun			1 Tye			es 2 No 3 Probably 4 Unknown	
The law rate has b	Completed	Derventa:			24a. Was al autops perforr 1 □ Yes			y prior to completion of cause of death?	
To the Hospital or Attending Physician: The law requires within 24 hours after death. To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be	Certification: To Be C	25. Was case referred to medical examiner? Hospital: Other:							
		1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	ent 3 DOA One: 4 Nursing Home 5 Residence 6 Other (Specify) of Very North Work? M 1 Yes 2 No						
		2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, suicide building, etc. (Specify)							
	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
To th withir To th comp	Me	29b. Signature and title of certifier	D			se number		d. Date signed (Me	
		30. Name and address of person who completed cause of death (Item 23			D42955 Ba) (Type, Print) 86 12d 1			Vestington Ma	
21		30. Name and address of person who 31. Date filed (Month, Day, Year)	Ut a	csa) (Type	5/2	12d.	1-4 0	Je. 86	you Ma
Sta Registr		JAN 2 0 2011	32. Registrar's Sign	park	/				
HMH 17 Rev 1/2	001			ORIG	GINAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

09th/14/2011

3. Time of Death

1755

2. Date of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** MC DONAL :15 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOMEWOOD NURSING CENTER BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 F Months Days Hours Min. 60 Director 216-54-1792 Usual Residence of Decedent 5-18-1950 MARYLAND Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 'natural", or items 23a or 28a-f show dical Experience quet be putitived at 1 ☑ Yes 2 ☐ No Director N/A BALTIMORE MD. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21229 Funeral 647 AUGUSTA AVE USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: Baltimore, Maryland 21215-0036 1 □ Yes 2 录No Specify: þ Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CUSTODIAN CHIMES 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဨ MARION McDONALD AUDREY REDDING 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health an Important: If item 27 is any Injury or other trau once. DOREEN WISE-PERRY (DAUGHTER) 831 STAMFORD RD. BALTIMORE. MARYLAND 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 3 Removal from State **b** □ Crema 4 □ Donation 5 Other (Specify) KING MEMORIAL PARK 1-25-2011 BALTIMORE, MARYLAND SQNATHAN. D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME. P.A. of Funeral Servi 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Approximate Interval Between Onset and Death 23a. Par 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest struck, it is heart failure. List only one cause on each line. Immedi Cause (Final **Physician** VA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ul Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Year signed by the a 5 Other (specify) TYes 2 TWO 9 D Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 - No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) à No မ 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

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wood Rd, Ste

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day,

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Partie les

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MD-21234

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Jane M. Owings -18-201:30A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2406 Barewood Road Parkville Balto. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months (Month, Day,) Maryland Director 218-32-6938 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must han maisted and injury or other traumatic event, the Medical Examinar must han maisted and injury or other traumatic event. 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Md. Balto. Parkville 1 Yes 2 XNo , 23a o. t be n' 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2406 Harewood Road 21234 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Principal Private School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Horace Lilley Frances England 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Billie Tracey DTR. 2406 Harewood Road Parkville, Md. 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 1-19-2011 Bayview Balto. Md. . Signature of Fund al Service Licenses 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Road Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Ovarian Cancer disease or condition CUX Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of). that the death certificate be executed burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Month Day Year 1 Yes 2 No 9 Unknown has been signed by the e 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 🙀 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No this certificate director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 \square Pending work?
1 \sum Yes 2 \sum No injury 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

25

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 12 per fh g912 2-3-11 vt
State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 01 Physician/ Day 2011 Lee Puderbaugh, Jr. 8 9:40 Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 610 Wardour Road Glen Burnie Anne Arundel Co. 8. Date of Birth (Month, Day, Year) 6/05/1940 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Min. 1 **X** M 2 □ F Hours Country)
Idaho Director 70 519-42-0722 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Glen Burnie Anne Arundel Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21061 610 Wardour Road United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ X Yes 2 ☐ No Yes, Give 1 ☐ Yes 2 X No Specify. Year or Dates. 61-00 Specify: 3 Widowed 4 Divorced Completed White the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Army Master Sergeant vrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ellen Mercer Ve1ma David L. Pauderbaugh, Sr. other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Doris Puderbaugh / Wife Glen Burnie, Maryland 21061 610 Wardour Road 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State permit. Page 1 Department of Important: If i any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1/25/2011 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 21. Signature of Funeral Service 22. Name and Address of Facility Singleton Funeral & Cremation M01121 Services PA, 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATI Physician/ UNG year disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the bunal-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death signed by the a d be detached f Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Probably 4 Unknown Completed should ! 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy performed 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Presidence 6 Other (Specify, 2 No 1 🗌 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Box 68760 P.O. Division of Vital Records, e Hospital or Attending Physician; The law in 24 hours after death.

The Funeral Director: A pleted filled in by the fu

within 72 hours after death with

al Hygiene.

and Mental H pe

ige 1 and 2 should be nt of Health and Mer It item 27 is marke

Maryland 21215-0036

Baltimore,

29b. Signature and title of certifier M.D. 122AC JASHINUZ 31. Date filed (Month, Day, Year)

JAN 20 2011

29a. Certifier

(Check

only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1600 Lain Hw

32. Registrar's Signature

Registrar

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year) 2011

Glen Burnic, MD 21061

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM#1perphys, C911,1/20/2011, WS State of Maryland / Department of Health and Mental Hygiene
amend #17 Per FH G911,1/25/2011 JH

Certificate of Death

Reg. No. 2011 Reg. No. 1. Degedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Physician/ Zoil Agnes Mae Ridgely Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Seasons Hospice Randallstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 XX Months April 29 Days Hours Marvland 84 Yrs ¹⁷1926 Director 220-12-8550 Usual Residence of Decedent or 28a-f show 10b. County 10a. State within 72 hours after death with the Maryland event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21244 7602 Clays Lane Apt. 115 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. o þ 1 Never Married 2 X Married 1 Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural", Specify: Completed 3 Divorced 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker own home 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Caltrider 2 George Ellsworth Ridgely Edna Mae Heaps permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke. any injury or other traumatic e once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Ridgely Husband 7602 Clays Lane Apt. 115 Baltimore, MD 21244 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X y Burial 2 ☐ Cremation 3 ☐ Removal from State Lorraine Park Cemetery Jan. 21. 2011 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) Fur eral Service Licer 21. Signature 22. Name and Address of Facility urrier-Oueen Funeral Home & Crematory 1212 W. Old Liberty Road Winfield, M 23a. P. rt 1. Inter the disease, or complications shoc or heart failure. List only one cause caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a each line. or complications the Approximate Interval Between Onset and Death Ir me ate Cause (Final (Trysician) se or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any additions are cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to for as a considuance of attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Pregnant at time of death the 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an has autops certificate 1 Yes Yes eral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🚺 No Other: 은 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 IDOA 5 Residence 27. Manner of Dea h 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural work? 5 Pending iniury Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To only one st of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of Certifie 29c. License number 29d. Date signed (Month. Day. Year) who completed cause of death (Item 23a) (Type, Print) 3 31. Date filed (Month State JAN 20 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ M ld Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution) give street and number) 4c. County of Death Examiner Joseph Richey House Baltimore na 8. Date of Birth (Month, Day, 2-14-Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 N C **Funeral** 1 □ M 2 🔀 F Hours N.C. 216-34-4970 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1X☐ Yes 2 ☐ No Baltimore MD na 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21218 2327 Guilford Avenue 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Black 1 Yes 2 No Specify: Completed 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ns
any injury or other traumatic event, the Madic
once. (Specify only highest grade completed) Elementary/Seconday_(0-12) College (1-4 or 5+) Waymon House Housekeeping 12th grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Bernice Nixon Joseph Hammond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21215 <u> Denise Rodgers- Daughter</u> 6602 Parr Avenue Balto, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-19-2011 Owings Mills, Garrison Forest East F/H March 21. Signature of Fun rvice Licensee 22. Name and Address of Facility MD 21202 Avenue Balto, 1101 E. North 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated are or injury) Due to for as a consequence oil. Exami burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 1 No Month Year Pregnant at time of death 5 Other (specify) signed by the a 9 | Unknown Unknown Hospital or Attending Physician; The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tyes been si should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed 1 Yes 2 No this certificate After this certifical funeral director, I **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specification) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 7. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury 5 Pending 1 Yes within 24 hours after death.

To the Funeral Director: At completed filled in by the fu 2 Accident 3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar

State

0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

JAN 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month :15 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Catonsville Baltemore 9. Birthplace (State or Foreign Country) UNK If Under 1 Year If Under 24 Hrs. 8. Date of Birth Z Age (In vrs. last birthday Funeral Social Security Number Feb 9, 1920 1 🗆 M 2 🔀 F Min Director 90 213-28-1223 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Baltimore Dunda1k 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7304 Martell Avenue 21222 USA 12. Was Decedent Ever in U.S. unk 13. Was Decedent of Hispanic Origin? (Specify Yes or No Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: white than "natural", 3 Widowed 4 Divorced Completed Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation unk (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry unk 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. unk unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Baltimore County Dept of Aging; Towson, MD 21204 Rosalyn Cooley-Prayer - guardian 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 ☑ Other (Specify) in State Signature of Funeral Service Licenses, Ronal OS 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 rt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ETASTATIO Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): physician sthe burial Physician/Medical that the death certificate be Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year signed by the a 2 No 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, 1 Yes 2 No 3 Probably 4 Onknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed' death? this certificate 2 [1 Yes Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, t 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Yes ျပ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 2 Accider
3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 28595 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MA AKHANI 2835 Xm1JH EEM Day, Year) 32. Registrar's Signature State **JAN 20**

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}2011 Physician/ 9:00 A M Virginia Alverta Skipper January 17, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1448 Medfield Avenue Baltimore N/A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Numbe 8. Date of Birth (Month, Day, Year) December 5, 9. Birthplace (State or Foreign **Funeral** 1 M 2 XX Months Mary Land 215-14-5368 88 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director ¥Yes 2 □ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1448 Medfield Avenue 21211 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force 1 Never Married 2 Married þ 1 Yes 2XX No 1 Yes XX No Specify: Specify. Completed 3 Widowed 4 □ Divorced white Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker In Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည unknown by informant Susie Melvinia Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joann Marie Clatterbuck Cousin 2002 Rockrose Avenue Baltimore, Maryland 21211 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a Method of Disposition 20c. Location - City or Town, State 1XXX Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial Park 1/22/2011 4 Donation 5 Other (Specify) Elkridge, Maryland van W. Clan 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road Baltimore, MD 23a. Part 1. Enter the disease, or complications shock, for heart failure. List only one cause of hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Vascular Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death signed by the a d be detached f a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Tes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has bage 2 s autopsy perform death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical

that the death certificate be executed Division of Vital Records, P.O. Box 68760 The faw certificate the Hospital or Attending Physician: director, this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral or

Baltimore, Maryland 21215-0036

Shiral

Be 26. Place of Death (Check only one) examiner? 2 **X** No Other: မ 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certif mo

State Registrar

30 31. Date filed (Month, Day, Year) SAN 2 0 20

32. Registrar's Signature

pleted cause of death (Item 23a) (Type, Print

Falls

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #12 Per FH G911 1/31/2011 JH

1	#12 Per	FH GYLL	1/31/2011 JH	
	 State of 	f Maryland	Department of Health and Mental Hygier	า
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Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Victor Beldon Stanley Jr. 01-09-2011 0300 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1400 S.Philadelphia Blvd Harford Aberdeen Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 😿 M 2 □ F Days Hours 72 Director VA 225-44-5208 Usual Residence of Decedent or 28a-f show 10a. State 10c. City, Town or Location 10d Inside City Limits Examiner must be notified at Director MD Harford Aberdeen 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21001 USA 1400 S. Philadelphia Blvd 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Vas Decedent Ever III 5.5. Armed Forces? Black White etc. 1 Never Married 2 Married Completed by If Yes, Give Year or Dates. 1 ☐ Yes 21 No Specify. 1958 White Specify: "natural", 3 Widowed 4 X Divorced permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter Gov't Employee Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Victor B. Stanley Sr. Mary A. Combs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tamara Butindaro (Daughter) 2101 Bayberry Rd Edgewood, MD 21040 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 01-18-2011 Owings Mills, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc 610 W. MacPhail Rd BelAir, MD 21014 Ce 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PROSTATE CANCER Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Vear 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ BENICH PROSTATIC HYPERPLANA 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 No 2 No 1 Yes _ Yes Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 No ၉ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🗹 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Matural Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 📈 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) elig W. Habsterd D0020803 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 602 JOH ATWOODED LUTTE 101 BEL AIR MY MICH Day, Year) **Q** 0 31. Date filed (Mo State Registrar

Baltimore, Maryland 21215-0036

Box 68760

Records, P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month JAN **Physician** THORME THOMAS AUGUSTUS D9:46 AM 2011 /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner Genera County Howard Columbia If Under 1 Year Social Security Number '. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Months Min. 1 **X** M 2 □ F 86 578-26-7693 Usual Residence of Decedent Yrs. 1924 Washington. **Director** 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Invoiced Evantines must be natified at 1 XYes 2 □ No Director 10e. Street and Number 10g. Citizen of What Country' Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ð 1 ☐ Yes 2 No 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) filed withir Hygiene. College (1-4or 5+) 17. Father's Name (First, Middle, Last) 2 should be fit and Mental H 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any injury or other trau Woodstock *Folkestone* 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Columbia 1 ■ Burial 2 □ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Altensee Service Funeral Baltimore Nationa 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final FAILURE KESPIRATORY **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner MASSIVE HOIZUARE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) requires that the death certificate be executed physician and the burial-transit DMG MASS resulting in death) Last Due to (or as a consequence of): Box 68760. SYNDROME ODYSPLASTIC Physician/Medical use as attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.0. cate has been signed by the page 2 should be detached 1 □ Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by HIEMIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Physician: The law 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate perforr 1 Yes 2 No N/A Vital 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation **N**atural within 24 hours after death.

To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 🗌 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) PHYSICIAN 0062704 18, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 1. DESM

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Jan. Physician/ Mary Proctor Taliaferro 201 11:55 PM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner N/A Baltimore Keswick Multicare Center If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Country)
Maryland Days Hours Min. (Month, Day, 1 □ M 2 🗓 F 212-16-6623 93 18, 1917 Director Usual Residence of Decedent 10d Inside City Limits 28a-f show 10b. County 10c. City, Town or Location 10a. State with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director Baltimore 1 ☐ Yes 2X No Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 21220 13213 Fast Greenbank Road permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black White etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 3 X Widowed 4 □ Divorced Completed Year or Dates 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker At. Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bessie Brady ٥ William Emory 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 13213 East Greenbank Road Baltimore, MD 21220 (Daughter) Mary P. Miller 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date ob. Place of Disposition (Natire of Commenter), crematory or other place)
St. Thomas Fpiscopal
Church Cametery January 24, 2011 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Fixons Funeral Chapel & Cremation Services—Parkville
8800 Harford Road Parkville, Maryland 21234 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ahon Immediate Cause (Final ATVIAL Physician. disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 - Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Ves 2 No Month Year Day Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 Ē 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown evtension 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed? 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No filled in by the funeral director, 26. Place of Death (Check only one) Be Other: ျ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Accident Investigation hours after death 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 3 [29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier 29c. License number 18 2011 10 anuar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HIAVA DON M-D- 5901 NOVIN CHAVES BAL MOMILAND 5901 Don m.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 20 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 35 DM INAL 10 MA Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Seasons Hospice at Northwest Hospital Center Randallstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Social Security Number '. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M M 2 D F Days Hours Country) Maryland october 16, 1953 215-60-5806 57 **Director** Usual Residence of Decedent or 28a-f show 10a. State 10b. County aţ 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 🗌 Yes 2 🗹 No Pikesville Baltimore MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21208 USA 4617 Tema Road death v 12. Was Decedent Ever in U.S. Armed Forces?/
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. , o 1 Never Married 2 Married þ within 72 hours after 1 Yes : Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😿 No Specify: "natural", Completed 3 Widowed 4 Divorced Specify: Black Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed 12th Grade Landscaper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Melvin Thomas, Sr. Clarice Bell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Michelle Hughes - Sister</u> 4617 Tema Road Pikesville, Maryland 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 M Cremation 3 Removal from State 1/20/2011 Baltimore Maryland 4 Donation 5 Other (Specify) Green Mount Cemetery 21. Signature of Funeral Service Licenses ^{22. Name and Address of Facility} Chatman Harris Funeral Home 5240 Reisterstown Road Baltimore, Maryland 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause Final Onset and Death Physician/ disease or condition resulting in death) all Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Physician/Medical Examiner Due to (or as a consequence of) or or attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events resulting in death) Last signed by the attending physician and deed be detached for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? 1 Yes 1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Certificate: To Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence funeral (27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 🗌 No the Investigation 6 Could not be Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral D To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30. Name and address of person who completed use of death (Item 23a) (Type, Print) BMD

State Registrar 31. Date filed (Month, Day, Year,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 01047 State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death . Dec 's Name (First, Middle, Lac 2. Date of Death 3. Time of Death Physician/ January 1²4 2011 11:00am Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Greater Baltimore Medical Towson If Under 1 Year 8. Date of Birth (Mo) th. Day, **Funeral** Months Hours Director mit. Page 1 and 2 should be filed within 72 hours after death with the Maryland bartment of Health and Mental Hygiene. Sortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits 1 Yes 2 No Citizen of What Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 Never Married 2 Married þ 1 Yes 2 No Specify If Yes, Give Year or Dates 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (Fifst, Middle, 2 Informant's Name/Relationship 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ott Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Deponation 5 Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death Complications Smell GONE 065MUCTON disease or condition 6 drys Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, eading to in mediate cause. Enter Underlying Examiner Due to (or as a consequence or): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav Year 1 Yes 2 Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ infarcion, acute Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 Wo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospita 2 No 1 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) . Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 Natural injury 5 Pending Accident Suicide Investigation Could not be 1 Yes 2 No 6 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHMIRS M 6701 TOWSONMD 31. Date filed (Month, Day, Year, 32. Registrar's Signature State JAN 20 2011 Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law redu

	For State Registrar	State of	Marylan		artment of I tificate of I		nd Mei		giene Reg. No		0 1 0 48
ın/	1. Decedent's Name (First, Middle Konno Ho		MA.	ſ			2.	Date of Dea		<i>₹21</i>	3. Time of Death
er er	4a. Facility Name (if not institution	, give street and number		-	4b. City, Town, o			vun	4c. Cour	nty of Death	
	Seasons Hos 5. Social Security Number		Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24	Hrs. 8.	Date of Birt		g, Birthr	place (State or Foreign try)
_	215-50-8793 Usual Residence of Decedent 10a, State 10b. County	<u></u>		v. Town or Loc	cation			9-24	1-1952		MD Od. Inside City Limits
Director	MD n	a	1	Ltimor	ce e						1 X Yes 2 □ No
Funeral	10e. Street and Number 1820 St. Pa	ul Street			10f. Zip Code 2120	02			10g. Citizen o	of What Cour	ntry?
2	11. Marital Status 1 ★ Never Married 2 ★ Mar 3 ★ Widowed 4 ★ Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give	nt Ever in U.S es? [XNo	"	Vas Decedent of H f Yes, specify Cuba ☐ Yes 2 🛛 No	lispanic Origin an, Mexican, P	? (Specify uerto Rica	Yes or No- an, etc.)	14. R	ace - Americ lack, White,	etc.
completed	15. Decede (Specify only higher Elementary/Seconday (0-12)	Year or Date nt's Education est grade completed) College (1-4		(Give k life. D0	lent's Usual Occup kind of work done of O NOT use retired)	during most of	working		16b. Kind of	Business Ind	^{dustry} unk
D D	12th grade 17. Father's Name (First, Middle, I	,		Cus	stodial		,		Maiden Surna	me)	
ဍ	Robert Thom 19a. Informant's Name/Relations		ece	19b, Mailin	ng Address (Street	Ann i			r. City or Town.	State, Zip (Code)
	Cassandra A)2 Pulas				lto,		
	20a. Method of Disposition 1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		ate Kir	emetery crem	sition (Name of natory or other place morial	°e) Pk 1-	Date -13-2	2011	20c. Location Randa	n - City or To	own, State
	21. Signature of Funeral Service I	icensee)		Name and Addre				East		21202
	23a. Part 1. Enter the disease, or shock, or heart failure. List of immediate Cause (Final	complications that cau	line.	n. Do not ente	r the mode of dyin					O / IID	Approximate Interval Between Onset and Death
	disease or condition resulting in death)	a. Due to (or	as a consequ	m o	<u> 19</u>						
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events c.										
Physician/Medical Ex	resulting in death) Last	Due to (or d.	as a consequ	ence of):							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2 🗀 Feta nt at time of d	Ideath 3 🗆	Ectopic pregnand Other (specify)	су				Date of delive	ery Day Year
3	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.										
Completed							_	24a. Was a autop perfor	rmed?	prior to condeath?	osy findings available mpletion of cause of
å	25. Was case referred to medical examiner?	Hospital:			26. Pl	ace of Death (Check onl				
၉	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendir 2 Accident Investig	1 ☐ Inp 28a. Date of i (Month,		ER/Outpatien 28b. Time of injury	28c. Injun	4 ∐ Nursii y at t?	28d.		ence 6 00 ow injury occu		
cat	2 Accident 3 Suicide 4 Homicide Investigation Suicide Suici									ber or Rural	Route Number,
_			a Comment of the control	edge, death o	ccured at the time	, date and place	ce, and du	ie to the cau	use(s) and mar	ner as state	d.
Medical Certificat	(Check 2 Medical E	Physician: To the best xaminer: On the basis of Nurse Practioner: To	of examination	and/or investi	igation, in my opinio						
Medical Certificate:	(Check 2 Medical E	xaminer: On the basis of	of examination	and/or investi	igation, in my opinio	e time, date an	d place, ar	nd due to the	e cause(s) and r 29d. Date sign	ed (Month, L	ated.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year LEOPOLD TAPEREX 5 30 PM Ö 63 2011 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltman Nursmoltone HARFORD GARDENS 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Months Hours 1 M 2 □ F 079140566 Pennsylvania 4/28/19/6 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Baltimore 1X Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21214 4505 Harford Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 🛣 Yes 2 □ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation unic 16b. Kind of Business/Industry Un 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Fannin - friend 9708 Oakdale Avenue; Baltimore, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 █ Other (Specify) in State 21. Signature of the real S ryce Lice Lee Roll 1 H Wads 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Findisease or condition resulting in death) Due to (or as a confequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Christonasi Due to (or as a consequence of) brecenus IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical xaminer requires that the death certificate be executed

Physician

/Medical

Examiner

10a. State

Director

Funeral

þ

Completed

Be

MD

Funeral

Director

show

If than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

Is marked other than

1 and 2 should be fi Health and Mental I

permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other trae

72 hours after

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division or Vital Records,

or Attending

Hospital

burial-trar the as use

Examiner and attending physician Physician/Medical the signed by t þ Completed peen certificate has Be 10 After this Certification: within 24 hours after death.

To the Funeral Director: A completely filled in by the fi

3b.	was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical

Hospital: 1 Inpatient 2 ER/Outpatient 3□ DOA 28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1□ Yes 2 \ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

24a. Was an

autopsy performed

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death? 2□No 1 ☐ Yes

1 Yes 2 LNo 27. Manner of Death

5 Pending investigation 6 Could not be determined 28a. Date of Injury (Month, Day Year)

28c. Injury at Work? Iniury 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

cal

1 ☐ Watural

2 Accident

3 Suicide

4 Homicide

1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number 31464 29d. Date signed (Month, Day, Year) 01104/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

St Sinte 308 BALTIMORE MAPHOMI 821 N. Entru MD 21201 7 HOALIS MD 31. Date filed (Month, Day, Year) 2. Registrar's Signature JAN 2 0 2011

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 12 Year 2011 **Physician** January 2:40 Charles George Tyransky /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 5021 Wright Avenue If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yes April 10, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Days Hours 1**™** M 2□ F Pennsylvania 1919April Director 120-12-6700 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show traumatic event, the Medical Examinar must be notified at Yes 2 No Director Baltimore MD the ! 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö USA 21205 5031 Wright Avenue Items 23a Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 Elyes 2 □ No 1943—
If Yes, Give
Year or Dates: 1945 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Specify: white 3altimore, Maryland 21215-0036 ō 1 ∐Yes 21X No Specify. ģ 3 X Widowed 4 ☐ Divorced "natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4or 5+) I be filed within intal Hygiene. Elementary/Secondary (0-12) Ottenberg Bakery baker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sophia Christovich Alex Tyransky 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 and Department of Health a Important; If Item 27 Is any Injury or other trau 605 South East Avenue; Baltimore, MD 21224 Linda Fullwood - daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board ure of Euneral Service I icensee Wade 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause If in al Physician MONTHS a. MYELDDYSPLASTIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed burial-transi and Due to (or as a consequence of): Box 68760. physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) P.O. I 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown CORONARY ARTERY DISEASE Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an CHRONIC OBSTRUCTIVE LUNG DISEASE performed 1 ∐Yes 2 **⊠**Ño 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending al or Atternative and after death.

seral Director: β

v filled in by the 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 01-13-2011 00032186 Maes M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CONRAD MAY M.D., BALTIMORE VAMC, 10 N. GREENE ST., BALTIMORE MD 21201

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 20 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 4:35a Gladys Thomas Jan 13, 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** 816 Wicklow Road 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Country) Virginia 1 M 2 F (Month, Day, Year) Sep 13, 1923 Director Yrs 218-14-6314 87 Usual Residence of Decedent 28a-f show 72 hours after death with the Maryland aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 🖰 Yes 2 🗆 No **Baltimore** Maryland **Baltimore City** or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 816 Wicklow Road 21229 U.S.A. items 1. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Armed Forces Black, White, etc. or, þ 1 Never Married 2 Married 1 ☐ Yes 2 🗶 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: "natural", Specify Black 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) other than filed within Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Hygiene. the Homemaker traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be file tment of Health and Mental I tant: If item 27 is marked o n and Mental 7 is marked o မ John Rivers Glen Rivers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 816 Wicklow Road Baltimore, Maryland 21229 Eugene Thomas item 2 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of IImportant: If ite
any injury or ot
once. 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 5. Other (Specify) 01/24/11 Owings Mills, Md. 4 Donation Garrison Forest Veterans Cemetery uneral Service License 21. Signature 22. Name and Address of Facility Estep Brothers Funeral Service, P. A 1300 Eutaw Place Baltimore, Md 213 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Failure To Medical resulting in death) Due to (or as a consequence of): Examiner DEP Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or linjury de nentica that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Por Month sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No this certificate 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 100 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death s after death. 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a To the Funeral D Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) Anne Lewis Low 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles 4105 BAH INCOC. 31. Date filed (Month, Day, Year) State JAN 2 0 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Vear SALIF 17:07 PM LURNER JANAURY Medical 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HARBOR HOSPITAL BALTIMOR Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Min. Months MO72111940 70 216 36 8288 Maryland Director Usual Residence of Decedent 10a. State 10b. County the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f N/A Baltimore 1 K Yes 2 □ No Maryland Maryland 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral Page 1 and 2 should be filed within 72 hours after death with U.S.A. 3620 - 5th Street 21225 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Completed White Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done duning most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Clothing Simms Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Howell Elliott Frances Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Turner / Son 8079 Pen Dragon Way Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Baltimore, Maryland 01/20/2011 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 21a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician HEMORRHAGIC ANCREATITIS disease or condition Medical resulting in death) Examiner COUGALADATT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine RESPIRATORY burial-transit and Due to (or as a consequence of): attending physician for use as the burial LEUKEMI Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be up the Yabours after death.

The Funeral Director: After this certificate has been signed by the attending physician poleted filled in by the funeral director, page 2 should be detached for use as the burpleted filled in by the funeral director, page 2 should be detached for use as the burpleted. P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months? Pregnant at time of death Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ PNEUMONIA Records, 1 Yes 2 No 3 Probably 4 Unknown Completed ATRIAL FIBRICLATION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2: autopsy performed 1 Yes 2 No Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes ဂ္ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 7. Manner of Death Certificate: 28b. Time of 28c. Injury at Natural 28d. Describe how injury occurred 5 Pending work? 2 Accident
3 Suicide
4 Homicide 2 🗆 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 only one) 29b. Signature and title of certifier JANAURY, 15, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

SOURABH VERIYA

JAN 20

31. Date filed (Month, Day, Year)

HANOVER

ST

3001

32 Registrar's Sig

BALTIMORE -21225, MD

11-00391 John J. Tart Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

John J. Tart		1- For State Registrar	tate of Maryla		oartme <i>ertifica</i>			I Menta	l Hygiene	2 0 1 Reg. No.	1 01053
Physicia Medical Examin		M									3. Time of Death 2225 hrs
		4a. Facility Name (if not instituti McCready Hospital	on, give street and nu	mber)		41	Crisfield	ocation of D		4c. County of Somerse	
Funeral Director		5. Social Security Number 217 94 4604	6. Sex	7. Age (In yrs 47	s. last birth	day) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	_		9. Birthplace (State or Foreign Country) Mary Land
land f show any pace.	or		erset	10c. Cit	ty, Town o Mari		n				10d. Inside City Limits 1 Yes 2 X No
the Maryland a or 28a-f show	Director	10e. Street and Number 28090 Hollan	d Crossing	Road			10f. Zip Code 2183	38		10g. Citizen of Wha	t Country?
s aft	d by Funeral	11. Marital Status 1 Never Married 2 N 3 Widowed 4 Div 15. Decedent's Education (Spe	Armed Fo	2X No		If Yes	Decedent of Hisp is, specify Cuban, Yes 2 X No	Mexican, Pu		No- 14. Race - White, Specify: 16b. Kind of Busi	White
OO36 Vithin 72 ho grene. ber than "na ber than "na the than "na the than "na the than the than the than the than the the than the the the the than the the the the the the the the the the	Completed	Elementary/Secondary (0-12) 12th 17. Father's Name (First, Middle		-4 or 5+)	_ du	_	penter				ruction
MD 21215-0036 d.2 should be filed within 7 lin and Mental Hygiene. In 27 is marked other than 10 market ovent, the Medies to the Medies of the	8	19a. Informant's Name/Relations	Willia hip (Type, Print)	m Patr			Sr.	E	velyn Pa	,	State, Zip Code)
re, MD s I and 2 sh f Health and If item 27 i	-	Julia Tart / 20a. Method of Disposition 1 Burial 2 Cremation				Dispositi	on (Name of ceme		pt. 22 C		aryland 21114 lity or Town, State
Baltimore, permit. Pages l an Department of Het Important: If ite injury or other it	L	4 Donation 5 Other Sp. 21. Signature of Funeral Service	pecify:	Ce		Hill 22. Na	Cemeter	f Facility (once Fun	eral Serv	re, Maryland ice, P.A. aryland 21225
Physician /Medical Examiner		23a. Pert I. Enter the disease, of failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	complications that ca on each line.	used the deat	opneu	enter the	mode of dying, su	ich as cardia	ac or respiratory a		_
ed nsit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last	b. Due to (or as a c. Due to (or as a	eon eoquontea	ot).						_1
so, te be executed ysician and burial - transit		X UNPENDED	AMENDED 23a	.27.pe	r ME	g913	3/3/11	TT			
Box 6876 e death certificat the attending ph ed for use as the	ΣI	F FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unk	e 1 Live bir	int at time of d	2	=	death 3 (Specify)	Ectopic pre	gnancy	23d, Date of de Month	elivery Day Year
S, P.O. uires that the n signed by id be detach	6	Part II. Other significant condit	ons contributing to	death but not	resulting ir	n the und	erlying cause give	en in Part I.	1 Ye	es 2 No 3	te to the cause of death? Probably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been siled in by the funeral director, page 2 should be artification: To Be Committeed	panaldulo	:5. Was case referred to medical					20 Diago et	Dooth (Ob.	1 ✓ Yes	psy pno ormed? dea	re autopsy findings available or to completion of cause of the? Yes 2 No
Physician: This certifical director, To Bo C	2	examiner? 1 ✓ Yes 2 No	Hospital: 1 In	patient 2	ER/Outp		DOA Ot	her ₄ Nu		Residence 6	Other: Scene
Sion of Attending Ph death. sctor: After 1		7. Manner of Death 1 X Natural 5 Pend 2 Accident Inves	ing tigation	Day,Year)		ne of Inju	1 Yes	2 No		how injury occurred	
S to de G = Suicide 6 Could not be determined (Specify) 3 Suicide 6 Could not be determined (Specify)							State)				
To the Hos within 24 h To the Fun completely	במונים	Check only 2 Medical Exar	niner: On the basis of and manner sta	examination a	dge, death and/or inve	occurred	, in my opinion, d	eath occurre	and due to the cau d at the time, date	and place, and due	to the cause(s)
		9b. Signature and title of certifier	, 🗸				29c. License n O.C.M.			January 14, 2	(Month, Day, Year)
ØV	3	Name and address of person Ling Li, MD Assistar	who completed cause nt Medical Exam		,	imore	Street, Baltim	ore, MD	21223		
Stat Registra	_	1. Date filed (Month, Day, Year)		strar's Signat	ure /		in				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Da 1-18-2011 Physician/ 8:25р м Doraetta Amelia Vaughn Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Riverside Nursing 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Hours Min. 1 🗆 M 2 😾 F Yrs. 218-26-6014 81 9-6-1929 Director Maryland Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Essex 1 Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Eastern Blvd. 21221 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Forces Black White etc þ 1 Never Married 2 Married Yes 2 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic. Elementary/Seconday (0-12) College (1-4 or 5+) In own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည unk Ruth Sneeringer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael V. Vaughn Sr. Oakway Ct. Joppa, MD 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/24/2011 |Baltimore,MD Louden Park 22. Name and Address of Facility Joseph N. Zannino Jr.FH 21. Signature of Funeral Service Licensee 263 S. Conkling St Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure/List only one cause on each line. Approximate Interval Between Acute cerebrianular Immediate Cause (Final accidon Pnysician/ Medical resulting in death) Due to (or as a consequence of): Examiner nertonsion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consil To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Mellitus congestive 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 24 hours after death.

Funeral Director: After this certificate I within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 ☐ No Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death Natural 28b. Time of 28d. Describe how injury occurred 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 69540 M.D. 20 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) words Rd Swite 204 Parkville MD 21234 8413 Wal man Shah 31. Date filed (Month, Day, Year) ·32. Registrar's Sig State Registrar

HMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** John Richey Vorwerck 8:05PM 8 - 11 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Manor Care Ruxton Towson Baltimore County If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Min 12 M 2□F Yrs. 93 May 14,1917 Miamisburg, Ohio 230-01-8387 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐Yes 2 No "natural", or Items 23a or 28a-f sl edical Examiner must be notifled Director Baltimore County Cockeysville Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 10535 York Road 21030-8387 Apt. 228 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: White Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene.

27 Is marked other than 'r traumatic event, the Me College (1-4or 5+) 08 Elementary/Secondary (0-12) 12 Millenium Chemical Chemist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fill f Health and Mental H item 27 Is marked oth Be John Clifford Vorwerck Bessie Jane Richey P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21030-4846 19a. Informant's Name/Relationship (Type. Print) Cockeysville, MD. permit. Pages 1 and Department of Health Important; If Item 27 any injury or other tr Mr.John S.Vorwerch (Son) 1017 Misty Lynn Circle Apt.A 20c. Location - City or Town, State (Harford County) 20h Place of Disposition (Name of Date 20a. Method of Disposition Evans Funeral Chapel and Thursday 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jan. 20, 2011 Forest Hill, Maryland Cremation Services, Inc. 21. Signature of Funeral Servicey Licenses Jeffrey L. Gair, Sr. 22. Name and Address of Facility
Feaceful Alternatives Funeral and Cremation Center, P.A. WW.Lic.#M00677 2325 York Road Timonium, Maryland 21093-2215 23a. Pack. Enterthe disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or pach line. Immediate Cause (Final disease or condition resulting in death) **Physician** neumonia 01 Trali /Medical Due to (or as a consequence of): hronic Esquentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-trar Due to (or as a consequence of) Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 HHRnown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy page performed 2 DN 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA P 1 Inpatient funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Watural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide

Examiner that the death certificate be executed Box 68760; physician attending properties for use as P.O. ed by the detached signed t Records, as 2 certificate or Vital this c I direc After Division Hospital or Attending death.

death with the

filed within 72 hours after

Maryland 21215-0036

Baltimore,

Director: / in 24 hours the Funeral Dire hours after Medical

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

H0054424

1-19-

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dundaik Ave, Dundaik, MD 21222 rus Asadi, 3029

State Registrar

and manner stated.

To the within

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Villani 2011 11:35 PM R. Albert January Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Center Towson If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Days Hours Min. (Month, Day,)
March 10, Maryland 216-52-1293 Director 60 Usual Residence of Decedent or 28a-f show s notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland Director 1 ☐ Yes 2 ☐XNo Dundalk Maryland Baltimore 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? 5 pe 23a Funeral 21222 USA 7615 Gum Road must death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 5 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 within 72 hours after Specify: White If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural" Completed 3 Widowed 4 Divorced th and Mental Hygiene.
7 is marked other than "natur traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Baltimore County life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Government 12 years Supervisor Be Department of Health and Mental His Important If Heal 27 is marked oth any injury or other traumative once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Agnes Fox Edward R. Villani 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7615 Gum Road, Baltimore, Maryland wife 21222 Barbara Villani 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Januaty 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Bayview Crematory 19, 2011 Signature of Funeral Septice Lick Connelly Funeral Home Of 7110 Sollers Point Road, Dundalk, P.A. Dundalk, MD. 21222 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Monsmell months Curanna disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine Cause (Disease or iinjury that initiated events executed the burial-transit and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? jo Month Day 5 Other (specify) Pregnant at time of death Yes 2 No ed by the a 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? has certificate or Attending Physician: 25. Was case referred to medical To Be 26. Place of Death (Check only one) funeral director, Other: 4 Nursing Home 5 Residence 6 Wother (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: Al
completed filled in by the fu Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 58303 2011

Registrar

DHMH 17 Rev 7/2009

State

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N-Charles ST

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HARVES

32. Registrar's Sign

31. Date filed (Month, Day, Year)

JAN 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month EDMUND JOSEPH VITEK Medical 5:5 CM 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Glen Burnie Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) 1 🗷 M 2 🗆 F Days 218 28 7071 Hours Min. Month, Day Director 78 MD Usual Residence of Decedent show 10a. State 10b. County Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits 28a-f MD Anne Arundel Glen Burnie 1 Yes 2 No ò 10e. Street and Number 10g. Citizen of What Country? or items 23a Funeral 103 Beth Road 21060 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Never Married 2 Married Completed by Yes 2 No 1952 Black, White, etc. Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar any injury or If Yes, Give Year or Dates. 1 ☐ Yes 2 No Specify 3 Widowed 4 N Divorced 1955 Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Nuclear Engineer Westinghouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Joseph F. Vitek Margaret E. Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patti Skews - Daughter 14518 Church St. Upper Marlboro, MD 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Veterans Cem 1/19/2011 Crownsville, MD 21. Signature of corral Source Licensee 22. Name and Address of Facility GJ Gonce Funeral Home, PA 169 Riviera Drive Pasadena, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ rog ressive damentie Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, it airy, leading to immediate cause. Enter Underlying Cause (Disease or impury that initised as or injury) Examine Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed2 Yes 2 No this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred of medical Be 26. Place of Death (Check only one) 2 No မ 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending iniury of Funeral Director: A Funeral Director: A sletted filled in by the filled Accident 1 Yes 2 No Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D71488 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 Motameni, MD Hospital Drive Glen Burnie, 31. Date filed (Month, Day, Year) JAN 20 2011 Registrar M DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5perFH,G9T2,2/8/2011,W3 #20b
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 17, Evelyn Watts 20 Tear Μ. 8:48 AM M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 2**27-50-2537** 287-50-253 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb 11, 1939 **Funeral** 9. Birthplace (State or Foreign Months Days Director 71 Virginia Usual Residence of Decedent 28a-f show 10a. State 10b. County traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Forestville 1 X Yes 2 No 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7002 MountForest Terrace 20747 U.S.A. items death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ö þ 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Specify: Black Completed 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Medic 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) A.I.D. Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Edward Neighbors Sallie Jane Morris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carla Watts (Daughter) 7002 Mount Forest Terrace, Forestville, MD 20747 20a. Method of Disposition 20c. Location - City or Town, State Ne 12 150 Cametery 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donaţion 5 ☐ Other (Specify) Church Cemetery 1/22/2011 Buckingham, VA 21. Signatur f Funeral Service Licen 22. Name and Address of Facility Reid's Funeral Home 15317 N. James Madison Hwy., Dillwyn, VA 23936 23a. Par 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last signed by the attending physician and d be detached for use as the burial-trar Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis. IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Year Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Deep Venous Thrombosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4☐ Unknown Completed Metastatic Brain Cancer Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? ဂ္ 1 🗌 Yes 2 X No Other: 1-X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 Yes 2 No Investigation 6 Could not be filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Ma

Emeric Palmer, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

92. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

DHMH 17 Rev 7/2009

29c. License numbe

D69946

1500 Forest Glen Rd., Silver Spring, MD

29d. Date signed (Month, Day, Year)

201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Mar		artment of r rtificate of		•	Reg. No.	1	9 009
	D		1. Decedent's Name (First, Middle, La	est)				2. Date of Dea	ath Day	Year	3. Time of Death
	Physici /Medic		PRISCILLA	WASHU	STON				15, 201		8:30 A ^M
	Examin		4a. Facility Name (If not institution, given				or Location of Deat	4c. County	of Death		
4.72			Arcola Nursing			Silver	_			gome	-
	Funeral		5. Social Security Number 6. S	Sex 7.Age (1 □ M 2 □ F X	(In yrs. last birthday) O 5 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	(Month, Da	y, Year)	Coui	
н	Director		186-20-7490 Usual Residence of Decedent	X	85 Yrs.		<u> </u>	April 8	, 1925	Wash	ington, PA
	land ow		10a. State 10b. County	1	0c. City, Town or Lo	ocation				1	0d. Inside City Limits
	Mary -f sh	to	MD Montgom	erv	Wheaton						1 □Yes 2 □ No X
	r 28a	Director	10e. Street and Number	Cly	Wileacon	10f. Zip Code			10g. Citizen of V	/hat Cour	
	filed within 72 hours after death with the Maryland I Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be routified at		11504 Channing	Drive		2090	2		USA		
	death	Funeral	11. Marital Status	12. Was Decedent Eve	er in U.S. 13.	Was Decedent of H	Hispanic Origin? (S	pecify Yes or No	14. Rac		can Indian,
و	after or ite		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 □Yes 2½ No If Yes, Give		1 ☐ Yes 2 ☐ No		o nican, etc.)		k, White,	etc.
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ر ک	72 h 'natu	Completed	15. Decedent's E (Specify only highest gra	ducation a <i>d</i> e co <i>mpleted)</i>	(Give	dent's Usual Occup kind of work done	during most of wor	king	16b. Kind of Bu	siness/In	dustry
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Maryland 21215-0036	ontal led of	Be	Leroy Vactor	,				Vactor		٠,	
Ē	hould id Me mark matic	우	19a. Informant's Name/Relationship	Time Print)	10h Maili	na Address (Street			or Cify or Town	State Zir	Code)
<u> </u>	d 2 s Ith an 17 is trau			(Daughter)		4 Channi					, 0000)
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Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot		21. Signature of Funeral Service Lice	··	Washingt	on Cemete		<u>10−11 </u>	Washir	-	, PA
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	/Medical		disease or condition resulting in death)	a. Due to (or as a c						\rightarrow	
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			IF FEMALE:	23c. if yes, outcome of	pregnancy				23d Dat	e of deliv	en
ŏ	atter for u	ciar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 [4 ☐ Pregnant at tir	Fetal death 3	☐ Ectopic pregnand ☐ Other (specify) _	У		Mo		Day Year
j.	w requires that the death cert been signed by the attendin should be detached for use a	Physician/M	1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown	9 🗆 Unknown							
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ecords	s bee	Completed						24a. Was	an 24b. \	Vere auto	psy findings available
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ō	ng Pl	ü	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day, Y	28b. Time o	f 28c. Inju	ry at k?	28d. Describe h	ow injury occurr	ed	
202	endli eath. or: A	atio	2 Accident investigation				Yes 2 □No				
<u> </u>	r Att	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury building, etc. (At home, farm, str (Specify) 	eet, factory, office		28f. Location (S City or Tou	Street and Numb vn, State)	er or Rura	al Route Number,
ב	urs a		One Consider at Manual in a Di	tradicione To the book of		L		and due to the			No.
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	o the	Me	29b. Signature and title of certifier	2 //		29c. Licens	se number		29d. Date signe	(Month,	Day, Year)
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•		ŀ	30. Name and address of person who	completed cause of deat	th (Item 23a) (Type.	Print)				111	2 0 6 0 0 0 0
	D		BARRY RESENBA	UM 372	O FARI	RACUT.	AUE +	KERSIN	GTON	Jul ?	20894
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First Middle, Last) 3. Time of Death Day Month Physician/ 5.15PM 2011 Jan Medical 4a. Facility Name (if not institution, give street and num 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Baltimore 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number **Funeral** County an an Months Days Hours Month, Day, **Director** Usual Residence of Decedent or 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No 10e. Street and Numbe 10g. Citizen of What Country? Funeral 1165 Washin Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubap, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) abore Be 18. Mother's Name (First, Middle, Maiden Şurname, ဂ္ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Poute Number Wilson 513 N. 20a. Method of Disposition 20b. Place of Disposition (Name of emetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses evin tayle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): attending physician and for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Box in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day To the Funeral Director: After this certificate has been signed by completed filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes **Division of Vital** To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 XNO 1 Tes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 No hours after death. Investigation ☐ Accident ☐ Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 So Hanover St. Beltamora Edo, MD

Registrar

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	Physicia		Decedent's Name (First, Middle, Las	Hoover	Hoover Whitaker				th Day Year	3. Time of Death	
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-1			Esther's Place			BaHi			Battim		
	Funeral Director		5. Social Security Number 6. Social Security Number 185–24–6266 12 12 12 12 12 12 12 12 12 12 12 12 12	7. Age (In yrs. la 83	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birtl (Month, Day 10-2	Year) Co	rthplace (State or Foreign ountry) N.C.	
	Aaryland 8a-f show tified at	rector	10a, State 10b. County		Town or Loc					10d. Inside City Limits 1 ☒ Yes 2 ☐ No	
:	s 23a or 2 ust be no	Funeral Director	10e. Street and Number 841 N. Washi	ngton Street		10f. Zip Code 212	:05		10g. Citizen of What C	ountry?	
9036	oud be filed within 72 hours after death with the Maryland do Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "natural" or items 25a or 28a-f show matic event, the Medical Examiner must be notified at	ρχ	11. Marital Status 1 □ Never Married 2X Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		Vas Decedent of Hi f Yes, specify Cuba ☐ Yes 2 🛣 No		pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. Race - Ame Black, Whit Specify:		
Baltimore, Maryland 21215-0036	thin 72 hou ene. than "natu h- Medica	Completed	15. Decedent's Et (Specify only highest gra		(Give I life. D	lent's Usual Occup kind of work done of O NOT use retired)	luring most of wor	king	16b. Kind of Business Bethlehe		
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, Mary	2 she than 7 is trau		19a. Informant's Name/Relationship (T) Carrie Whitak	er-Wife					City or Town, State, Zi		
timore	Page 1 nent of int: If ii		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State K i	ace of Dispo emetery, crem ng Me	sition (Name of natory or other plac MOTIAL			20c. Location - City of Randallst		
Bal	permit. Departn Imports any inju		21. Signature of Funeral Service Licens	Green	_]	. Name and Addres	North A	Avenue	ast F/H Balto, N	4D 21202	
- p	nysician Medical		23a. Part 1. Enger the disease, or come shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Alumon	, 'A	r the mode of dying	g, such as cardiac	or respiratory arro	est,	Approximate Interval Between Onset and Death	
- S.	Examiner	ner	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of): Due to (or as a consequence of):							years	
8760	physician and the burial-transit	al Examiner	Cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a consequence	ence of):						
09/8	physic the bu	Medical		d				_			
Sox 6	5,6	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 Live Birth 2 Fetal 4 Pregnant at time of d	death 3	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	elivery Day Year	
ords, P.O. I			Part II. Other significant conditions of				en in Part I.		bacco use contribute to	o the cause of death?	
Hecords,	certificate has bee irector, page 2 sho	Completed by						24a. Was a autop perfor	sy prior to med? death?	ntopsy findings available completion of cause of	
Vital	certific rector,	Be	25. Was case referred to medical examiner?	Hospital:		Otho	ace of Death (Che	, ,			
on of V	ath. ; After this e funeral di	icate: To	1 Yes 2 No ' 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	ER/Outpatien 28b. Time of injury	28c. Injury	4 ∐ Nursing H at		ence 6 🗹 Other (Spec ow injury occurred	ity)assisted living	
DIVISION	rs after dez al Director led in by th	al Certificate:	3 Suicide 6 Could not be 4 Homicide determined		me, farm, stre	et, factory, office			on (Street and Number or Rural Route Number, Town, State)		
the Hoeni	To use tropping on channing rapstrain. The law within 24 hours after death. To the Funeral Director; After this certificate has I completed filled in by the funeral director, page 2 s	Medical	(Check 2 ⊔ Medical Examin	ician: To the best of my knowle ner: On the basis of examination e Practioner: To the best of my	and/or investi	igation, in my opinio leath occurred at the	n, death occurred a time, date and pla	at the time, date ar ice, and due to the	id place, and due to the cause(s) and manner as	cause(s) and manner stated. s stated.	
	. № 5 00		MILIO — C	RNP		29c. License			29d. Date signed (Mont.		
	60		Maia Holden	ompleted cause of death (Item 4940 Ea	23a) (Type, Pi Sterr	R16	Baltim	ore, M	0 2122 4	/	
	Stat Registra	-	31. Date filed (Month, Day, Year) JAN 2 0 201	3. Registrar's Signat	· pa	Kel					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 19a, per Int G912, 2/1/11 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2011 12:30 PM January <u>Doris Lucille Wiseman</u> /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Manor Care Dulaney Valley Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | Feb 5, 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral 1 □ M 2X F Maryland Director 83 216-20-0064 Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Marylanc 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f shov of cal Examiner must be notified at 1 ☐ Yes 2X No Director MD Baltimore Perry Hall 10e. Street and Number 10g. Citizen of What Country? 21128 USA 4528 Warmstone Circle Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🌠 No If Yes, Give Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: White Specify: þ 3 ☑ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) if Health and Mental Hygiene. item 27 Is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 12 banking data entry operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alda Elizabeth Harille Arthur Monroe Lewis ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4528 Warmstone Circle; Perry Hall, MD 21128 David B. Bowman - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or otl 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4⊠Donation 5 ☐ Other (Specify) 21. Sing the of Euneral Service Licensee Wade Trector 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each lipe. Immediate Ca (Final disease or condition resulting in death) CONGESTIVE and ISCHEMIC **Physician** /Medical years. Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 VNo
9 ☐ Unknown Month 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 1 Yes 2X No Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year) within 24 hours are: 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of cortifier 29c. License number 29d. Date signed (Month, Day, Year) D-12849 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A.H. GHILADI, M.D. 7600 OSLER Dr. TOWSON MD 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 20 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) - State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Survance White 13, 2011 2:30a Jan Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** N/A University Maryland Medical System 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗆 F (Month, Day, Year) Director 214-26-6884 Jul 10, 1930 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must he notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No **Baltimore** Maryland N/A 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A 1217 Cleveland Street 21230 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes ._2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ည Berdella Reaves Lawrence Reaves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 516 South Beechfield Avenue Baltimore, Maryland 21229 Cornelia Saddler 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 01/19/11 Lansdowne, Maryland Mt. Zion Cemetery Signature of Funeral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. A

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition) Approximate Interval Between Onset and Death Physician/ Chronic Obstructive Pulmonary Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami burial-tran resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 as the attending | IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Pregnant at time of death the detached 9 Unknown Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. signed | 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 Yes 2 No 3X Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2X No death? certificate 1 Yes 2 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 🔀 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1X Natural 5 Pending 24 hours after death. Funeral Director: A 1 Yes 2 No ☐ Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor **To the Fune** сотрleted fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 1336374321 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 South Greene Street, Baltimore, Md. 21201 Rafeena Bacchus,

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

JAN 2 0 2011

2. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** ILKENS 07:20 PM /Medical ΛI 6 2011 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner N/A Future Care Homewood Baltimore If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number Birthplace (State or Foreign Country)
 NC 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 D F 241-24-7979 78 Director 1/9/33 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits пs 23a or 28a-f show must be notified at MD N/A ty⊡Yes 2 □ No Director Baltimore 10f. Zip Code 10g. Citizen of What Country? 123 W. 29th St. - Unit 3E 21218 items 23a USA death v by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Examiner Black, White, etc. Pages 1 and 2 should be filed within 72 hours after on the file of Health and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: African Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No 3 Widowed 4 Divorced Amer. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Steel Elementary/Secondary (0-12) College (1-4or 5+) the Laborer 12 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul Wilkins Rovene Wilkins ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Miller Wilkins/Wife 123 W. 29th St.-#3E, Balt., MD 21218 item 27 l other tra 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Zion Cem. 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot My Burial 2 ☐ Cremation 3 ☐ Removal from State 1/22/11 Balt., MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hari P. Close F. Svs. PA 5126 Belair Rd, Balt., MD 21206-5105 21. Signature of Funeral Service Dicensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician disease or condition resulting in death) S /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending p 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Mknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an page 2 s has autopsy performed? Yes 2 No certificate 1☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2[**1**]No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ∏Yes 2 ∏No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director:

State

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

Year)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Year 22:26 M Charles William Ambrose JANUARY 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Union Memorial Hospital Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 ⊠ M 2 🛄 Months Days Hours Min. July 07 219-22-8309 **Director** 81 1929 Usual Residence of Decedent tal Hygiene. "natural", or items 23a or 28a-f show ed other than "natural", or items 23a or 28a-f show e event, the Medical Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 🗆 Yes 2 💂 No Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8412 Smallwood Court USA 21122 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 No ģ Baltimore, Maryland 21215-0036 1 Yes 2 X No If Yes, Give Specify. White 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If Item 27 is marked other fix any injury or other traumatic event, the longe. Barber Hair Cutting 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Herbert Ambrose L. Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael W. Ambrose 8416 Smallwood Court, Pasadena, MD 21122 (son) Date 24 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jan. 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Cemetery 2011 Elkridge, Maryland 21. Signature of Funeral Service Cicense 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ADVANCED 5 JUGITS Medical Due to (or as a consequence of) Examiner CARDIOMYCOOTH Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): signed by the attending physician and deetached for use as the burial-transit Cause (Disease or iinjury 10156.456 Due to (or as a consequence of): ARTOUR that initiated events resulting in death) Last Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 ATRAL FIBRIUMION IF FEMALE: outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Other (specify) Dav Year 1 Yes 2 L 9 Unknown 9 Unknown requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law rewinin 24 hours after death.

To the Funeral Director: After this certificate has b completed filled in by the funeral director, page 2 si autopsy performed? 1 🗆 Yes 2 🗷 No 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗆 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work?
1 Yes 2 No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cortifie 29c. License number 29d. Date signed (Month, Day, Year) M.D. AT 2438946-49 1,0 12011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALMMORE, MD 21298 JILLANI 201 E. UNIVERSITY BRUY 31. Date filed (Month, Day, Year)

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1:00 P January Albin Bukowinski 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Baltimore . Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Months Days Hours Min. 1 M 2 □ F Director 84 1926 225-38-1782 March 1, Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show traumatic event, the Medical Executors must be notified at Director 1 ☐ Yes 2 X No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 23a 644 Coleraine Road Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: or Items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married ≥ 1 ☐ Yes 2 💢 No Specify. Specify: White 3 Widowed 4 Divorced natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 6 Home Repairs <u>Handyman</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 0 John Bukowinski Mary Daciek 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other trau Stella P. Ayers, Sister 408 Dorchester Road Catonsville, Maryland 21228 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/20/11 Woodlawn Maryland <u>Woodlawn Cemetery</u> 21. Signature of Funeral Service License Thomas Gregor MacNabb Funeral Home, P.A. 301 Frederick Road Cátonsville, Maryland 21228 23a. Part 1. Enter the disease, complications I at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cau elon each line. Immediate Cause (Final **Physician** O3 days disease or condition resulting in death) /Medical Due to (or as a consequence of): 06 mont Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending p for use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) s been signed by the a should be detached 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 至 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 ☐ Yes 2 **D**No 2 12No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

68760 Box (Ö Records, Vital

Baltimore, Maryland 21215-0036

Pages 1

certificate has Division of

Hospital or Attending Physician: Tr 24 hours after death. Funeral Director: After this certificate tely filled in by the funeral director, pag within 24 hours a

To the Funeral I

completely filled

29a. Certifier

(Check only one)

29b. Signature and title of certifier

4GEGNEHU

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signa

10 State Registrar

Medical

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAR STOTHANN Month Janu<u>ary</u> 2011 6:59a Medical 4a. Facility Name (if not institution, give street and number) Worcester **Examiner** 4b. City. Town, or Location of Death Atlantic General Hospital Berlin Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 MD **Funeral** 1 □ M 2 😾 F Months Days Dec 24 Year) 923 Director 220-20-1425 MD Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. Count within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Worcester Berlin 1 □ Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 58 Mystic Harbour 21811 USA 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 ☐XNo Specify. Completed 3 X Widowed 4 ☐ Divorced Specify: white Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene, 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) homemaker domestic Be injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Michael Manley Rita Martin permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael M. Brohawn (son) 1277 Hoods Mill Rd., Woodbine, MD 21797 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Lake View Memorial 1-20-11 Sykesville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Pargistaight Serbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician + MEROSCERO MC disease or condition Medical resulting in death) ue to (or as a consequence of Examiner Brauns Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) 110 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral cirector, page 2 should be detached for use as the burial-transit YPENTENSION that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown ☐ Pregnam ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hospital or Attending Physician: The law requires Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 2 No 1 Yes Yes 2 Prohaw 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) 2 No Other: Certificate: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 2 Accident
3 Suicide
4 Homicide 1 Tes 2 No Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Mary Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signatu 15.2011 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 10324 OZD OCOMNCITY BLVD. BORUN, MD 21811 LOWIN COBTAMEDA 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item 10e per fh g912 2-11-11 vt State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11:55am [™] January 15, 2011 William Α. Briean, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carroll Hospice Dove House Westminster Carroll Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. Yrs. 214-18-9550 87 Jan. 1924 MD Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c, City, Town or Location 10a, State 1 and 2 should be filed within 72 hours after death with the Marylan Heatilt and Mental Hyglene.
Heatilt and Mental Hyglene.
A 71 is marked other than "natural", or items 23a or 28a-f show ther traumatic event, Ira Podical Exprise must be notified at 1 ∐ Yes 2 ∐XNo Director MD Carrol1 Sykesville 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code -861 Margo Court 21784 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 □Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 ☐No Specify: Specify: ģ WWII White 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Meter & Installation Utility Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William A. Briean, Sr. Estella Drager 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Darlene Restivo (Daughter) 955 Prince George Drive, Eldersburg, MD 21784 : If item 27 or other t Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Pages
Department o
Important: If
any Injury or Lorraine Park Cemetery 1/20/2011 Baltimore, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Licensee At 400764 PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (unas a consequence off-Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the aftending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐Yes 2 ☐No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and

DHMH 17 Rev 1/2001

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State Registrar ess of person who complete

_Name and add

31. Date filed (Month, Day,

P.O. Box 68760[©]

Smeet Westniveter, MD 21157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January. 16, 2011 Maurice E. Bowes 07:30amM Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Westminster Carrol1 Carroll Hospital Center Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Birthpia Country) **Funeral** 1 📈 M 2 🗆 (Month, Day, 19<u>33</u> Months Days Hours Director 206-26-1842 77 Mav Usual Residence of Decedent Show 10a. State ural", or items 23a or 28a-f sho Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🙀 No Carroll Westminster 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 3401 Avis Court 21157 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc ģ 1 Never Married 2 X Married 21215-0036 1 ☐ Yes 2 🕅 No Specify Specify: White Completed 3 Widowed 4 Divorced Korea 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Engineer NASA Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be filed the and Mental H 27 is marked of traumatic ever Maurice Bowes, Sr. Helen Harmon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh tment of Health ar tant: If item 27 is Mrs. Patricia A. Bowes (Wife) 3401 Avis Court Westminster, MD 21157 Department of Healt Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State All County Cremation 1/19/2011 Sykesville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Licenses Suanc 400764 PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician, disease or condition resulting in death) priestive oww Medical Due to (or a nsequence of) Examiner cute Ron Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Preumenre To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, ASCITES 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗌 No Investigation Accident Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Praction death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie ause of death (Item 23a) (Type, Print) as aheret beene & Alevender

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month January 18 2011 **Physician** 12:50 A.M Deneva /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not Institution, give street and number) Examiner Augsburg Lutheran Hone Baltimore Baltimore Birthplace (State or Foreign Country) 8. Date of Birth 1 (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 81 220-20-8577 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f show ant. If item 27 is marked other than "natural", or items 2a or 28a-f show ury or other traumatic event, If "Mary clock Event and be notified at ury or other traumatic event, If "Mary clock Event and December 2. 10d. Inside City Limits 10c. City, Town or Location 10h County 10a. State 1 ☐Yes 2 ▼ No **Funeral Director** Pikesville Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21208 8 Al-Hannah Circle 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: African-American Be Completed by 3 ☐ Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Fastfield Maryland Container Inspector 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elsie Smith Harry Kelson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8 Al-Hannah Circle, Pikesville, MD 21208 Charles Alexander/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Department o Important: If any injury or 1-24-2011 Druid Ridge Cemetery Pikesville, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Wylie Funeral Hone P.A. of Baltimore Co. 21. Signature of Funeral Service Licenses lle 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Into the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, to leart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause of University that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 2 ☐ W6 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: Nursing Home 5 Residence 6 Other (Specify) 1 🗖 Yes 21 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in ! 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier CRNP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Compfield Rd Balto CRNP 6811 Regiva By 31. Date filed (Month, Day, Year) Birch 32. Registrar's Signature State faces Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 11:41 PM Brown Larry 0. 2011 anuar /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Timore 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7 Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1**∑**M 2□ F Yrs. 65 216-42-4231 MD 03-17-1945 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show ral", or items 23a or 28a-f shov Exeminer must be notified at 1 XYes 2 ☐ No Director Catonsville MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21228 U.S. 1 Lincoln Ave. by Funeral Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐Yes 2X No Specify Specify: Black 3 Widowed 4 Divorced "natural", er than "natura , the Medical E Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental 0. Elizabeth James John Charles Brown 7 is marked traumatic e ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a Larry O. Brown, Jr. / Son 21 N. Monastery Ave / Baltimore, MD 21229 Department of Health Important; If item 27 any injury or other troone. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 1-21-2011 Riverdale, MD Riverdale Park Crem' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Tri-State Funeral Services, 21. Signature of Funeral Service Licens Inc. / 814 Upsher St, NW / Wash., DC 20011 w Nac Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Dary disease or condition resulting in death) /Medical Due to (or a disconsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Completed by Physician/Medical Examiner attending physician and for use as the burial-trans resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗌 Ectopic pregnancy in the past 12 months? Year Month Day n signed by the at 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 DUnknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, cate has been signated by page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2.2No 1 ☐ Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1☐ Yes 2☐No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural after death. 1 ☐Yes 2 ☐ No 2 ☐ Accident the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide e Funeral I 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier completely (Check only one) within 2 and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 16,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue, Baltimore 900 Caton 32. Registrar's Signature State Registrar

11-00455

Lavinia Margaret Bowen

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State of Maryland / Department of Health and Mental Hygiene	6011	
Certificate of Death		

		- For State	Certificat	e of Death		Reg.	No.	
	Physician/ 1. Decedent's Name (First, Middle, Last) cal Examiner Lavinia Margaret Bowen						ay Year	3. Time of Death
Medical Exami	ner	Lavinia Margaret			January 16,	2011	0906 hrs	
		 Facility Name (if not institution, give street and numl 7829 Marioak Drive 	ber)	4b. City, Town, or Elkridge	Location of Death		4c. County of Howard	Death
Funeral		5. Social Security Number 6. Sex 7.	Age (In yrs. last birthd			8. Date of Birth (9. Birthplace (State or Foreign
Director		219-66-3030 1 M 2XF	47	7 Yrs. Months Days	s Hours Min.	08/18/		Country) Germany
	ł	Usual Residence of Decedent			<u> </u>			
any	ĺ	10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits
nd show	Director	Maryland Howard		H	Elkridge			1 Yes 2 X No
Maryland 28a-f show d at once.		10e. Street and Number		10f. Zip Code	-	10g.	. Citizen of What	t Country?
he M	声	7829 Marioak Drive			21075		Ţì	ISA
5-0036 led within 72 hours after death with the Maryland Jygiene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once.			lent Ever in U.S. 1	3. Was Decedent of His	panic Origin? (Spe			American Indian, Black,
eath item	Funeral	1 Never Married 2 X Married Armed Ford	ces?	If Yes, specify Cuban	, Mexican, Puerto R	ican, etc.)	White,	etc.
<u> </u>		3 Widowed 4 Divorced If Yes, Give Year	2 <u>X</u> 140	1 Yes 2 X No	specify:		Specify:	White
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	d b	15. Decedent's Education (Specify only highest grade		cedent's Usual Occupat			6b, Kind of Busin	ness/Industry
72 hc	Completed	Elementary/Secondary (0-12) College (1-4	or 5+)	ring most of working life.	DO NOT use retire	a)		
0036 within iene. rer tha	ם	12 2		Landsca	per		Lands	caping
5-0 iled w Hygie I othe	Ŝ	17. Father's Name (First, Middle, Last)	_		18.Mother's Name (I	First, Middle, Mai	iden Surname)	
21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica	BB	John Pearson			Jean	Unkn	own	
D 21 should and Me 7 is ma	리	19a. Informant's Name/Relationship (Type, Print)	7.1	Mailing Address (Stree	t and Number or Ru	ral Route Numbe	er, City or Town,	State, Zip Code)
and 2 shortealth and tem 27 is traumatic		Walter Bowen (spous		39 Marioak				
imore, MD 2 Pages 1 and 2 shou ment of Health and N tant: If item 27 is n or other traumatic		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from		Disposition (Name of cer or other place)	netery, Jan		20c. Location - C	ity or Town, State
Pages ent of int: If		4 Donation 5 Other Specify:		Crematory I	- 1		Baltimo:	re, Maryland
Baltimore, permit. Pages 1 a Department of He Important: If ite	1	21. Signature of Funeral Service Licenson	1	22. Name and Address				ral Home, P.A.
E F G F W		Marshall Htall	noll	3111 Mou	ıntain Roa			
Physician		23a Fart I. Enter the disease, or conforcations that cau failure. List only one cause on each line.	sed the death. Do not e	enter the mode of dying,	such as cardiac or r	espiratory arrest	, shock, or heart	Approximate Interval Between Onset and
Medical	1		oinstinal Hemorrh	age				Death
Examiner		or condition resulting in death) Due to (or as a co	onsequence of):					
	L	Sequentially list conditions, b.						
	Examiner	if any, leading to immediate Due to (or as a co	onsequence of):					
	E	(Disease or injury that initiated events resulting in death) Last Due to (or as a co	onsequence of):					
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760, cate be executed physician and the burial - trans	/Medical	UNPENDED AMENDED	5perFH.G922	2,12/15/201	1.WS			
760, icate by physicate but the but	ž	F FEMALE: 23c. If yes, ou	tcome of pregnancy				23d. Date of de	elivery
687 ertific ding		3b. Was decedent pregnant in the past 12 months?			Ectopic pregnand	су	Month	Day Year
Box 68760, death certificate be the attending physic d for use as the bur	sic	1 Yes 2 No 9 ✓ Unknown 9 Unknown	at at time of death 5	Other (Specify)				112
. e + e	Physiciar	Part II. Other significant conditions contributing to d		the underlying cause o	iven in Part I	23e. Did toba	cco use contribu	ute to the cause of death?
5, P.O. irres that the signed by detach	全	•	-	·,,		1 Yes	2 No 3	Probably 4 🗸 Unknown
ds, equire een sig ould be	te Ed	-				24a. Was an	1 24b. We	ere autopsy findings available
ords law equi has t een 2 should	륍					autopsy performe	prid	or to completion of cause of ath?
Ze The page	Completed					1 ✓ Yes 2		Yes 2 No
Division of Vital Records, P.O. Box 68 has no Attending Physician: The law equires that the death certif is after death. al Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as	8	25. Was case referred to medical examiner?			of Death (Check on			
'Yi'	2	1 ✓ Yes 2 No	-				esidence 6 🗸	
ding Ph	إڃ	27. Manner of Death 1 ✓ Natural 5 Pending	Injury 28b. Tin ay,Year)		· _ l	8d. Describe hov	w injury occurred	1
siOr ttend death ctor:	慧	2 Accident Investigation			es 2 No			
Divisi pital or Att ours after d ours after d filled in by	Certification:	3 Suicide 6 Could not be	of Injury - At home, farm	n, street, factory, office b	uilding, etc. 2	8f. Location (Stre or Town, Stat		or Rural Route Number, City
Spital Dours filled	3	4 Homicide determined (Specify)						
Division To the Rospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of one) Certifying Physician: To the best of one) Medical Examiner: On the basis of one						
To the within To the comp	Medical	and manner state		29c. License				(Month, Day, Year)
	2	29b. Signature and title of certifier	_					
0,		Allen Drasse 4. ME		O.C.I	VI.E.		January 17,	ZVII
10	ſ	30. Name and address of person who completed cause		00 W. Baltimore S	troot Daltiman	MD 24222		
	لِي		-	oo vv. bailimore 5	eet, DaitiiiiOfe	-, IVID 21223		
St Regist	ate	31. Dat Addi Month, Day Year) 32. Regi	strar's Signature	1				
IVGGIS	النيد	100	The sales					

State Registrar 29b. Signature and title

30. Name and address of

31. Date filed (Month, Da

death (Item 23a) (Type, Print)

Registrar's Signature

all the state of the

completed cause

32.

29c. License number

Igned (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5:00 PM B1665 2011 Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner BALTIMORE TOWSON JILCHRIST HOSPICE CARE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days MAR 19 8228 Hours Min. MISSISSIPPI 1 M 2 X F 1940 40 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f shov 10a. State 10h County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at with the Maryland Director EREELAND 1 X Yes 2 No BALTIMORE MD10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Completed by Funeral 21053 WALKER permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner musonce. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) BALTIMORE COUNTY College (1-4 or 5+) Elementary/Seconday (0-12) OF EDUCATION RO Be 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ FELEN LOUISE SPOONER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WALKER ROAD FREELAND MD 21053 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 23/2011 WINFIELD, MD 22. Name and Address of Facility IN ZUMBOWN IFH & MONG.
6028 SYKESVILLE RO ELDERS BURG MY 21 91 Funeral Service Licensee Part ... Little the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Due to (or as a conse vence of): disease or condition resulting in death) mu Medical Examiner Sequentially list conditions. Examine if any, leading to immediate
Lase Enter Underlyin;
Cause (Disease or linjury Due to (or as a consequence of): physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant Ectopic pregnancy Month Dav Year in the past 12 months? signed by the atte 5 Other (specify) Pregnant at time of death Yes 2 No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes certificate has been si irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Cher (Specify) 욘 After this 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 \square Yes 27. Manner of Death 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Meertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number an some K125808 Anne Lowis Velanueva. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4105 **21** 2011 egistrar's Signat 31. Date filed (Moi State Registrar

A DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20b, perFH, G911, 1/25/2011, WS

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ E. 201^{Year} Robert Bratt January 19ay 7:36 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Harford Upper Chesapeake Medical Center Bel Air Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Augonth, Pay Year 1939 1 x M 2 . F 214-38-4606 71 Marwrand Director Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Harford 1 Yes 2x X No Belcamp 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21017 USA 1310 Lirope Ct. Apt. T 4 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 X Married Completed by 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Counterman Auto Parts Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) aryland Helen Gertrude Russell Robert Ernest Bratt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1310 Lirope Ct., Apt. T 4, Belcamp, MD 21017 Lois A. Bratt moré, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Loudon Park Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Balth 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licenses 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Atheroscuroti disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Muocard Due to (s a consequence of) resulting in death) Last Physician/Medical IF FEMALE. 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? Dav Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cerebrovascular accident 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Uncontrolled Diabetes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s performed? Yes 2 No Hypertension 25. Was case referred to medical 2 🗌 No 1 Yes Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 No Other: ᅆ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D

completed filled i Medical 29a. Certifier Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeremy Michalk 31. Date filed (Month, Day, Year) State Registrar

			S	tate of Maryland				_	•	
		_	State Registrar	tate of Marylana		tificate of D			eg. Né	01076
	Physicia	n/	1. Decedent's Name (First, Middle, Last)	vn E.		Brown		2. Date of Deat Month	Day 2011	3. Time of Death
-	Medic Examin		Eve1 4a. Facility Name (if not institution, give street	· J			Location of Death	Jan.	4c. County of Dear	1:33 A M
1)			Upper Chesapeake			Bel A			Harford	
	Funeral Director		5. Social Security Number 6. Sex 1 \square M	2 🗓 F 7. Age (In yrs. last to 89	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 1	9. Bir Yea <i>r)</i> 1921 Ma.1	thplace (State or Foreign untry) Cyland
	how how at	١	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Loc	ation				10d. Inside City Limits
- 0	Marylar 28a-fs otified	Director	MD Harford			Jo	рра			1 ☐ Yes 2 🖾 No
3	ith the 3a or 3		10e. Street and Number 1619 Hollingswort	h Road		10f. Zip Code	21085	1	Og. Citizen of What Co	
0	eath w items 2 er mus	Funeral	11. Marital Status	Vas Decedent Ever in U.S.	13. W	/as Decedent of His	spanic Origin? (Spen, Mexican, Puerto I	olfy Yes or No-	14. Race - Ame	erican Indian,
)36	after d al", or i xamin	þ	1 Never Married 2 Married 1	Yes 2½ No Yes, Give		Yes 2X No		nicari, etc.)	Black, Whit Specify:	e, etc. White
2-00	2 hours "natur:	Completed	15. Decedent's Education (Specify only highest grade co		6a. Deced	ent's Usual Occupa	ation uring most of workir	ng l	16b. Kind of Business	Industry
127	rithin 72 iene. r than	Com		college (1-4 or 5+)	life. DC	NOT use retired) memaker	anny medici vi wemin	·9	Own Home	2
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∞ Iryla	ould be id Men marke matic		Logan O. Spivey 19a. Informant's Name/Relationship (Type, Pr	rint)	Ob Mailin	a Address (Street a	Mary M.		City or Town, State, Zij	n Code)
_ EX	nd 2 sh ealth ar n 27 is ier trau		Andrew J. Brown, Jr		3100	Greenhi	II Road		e, Maryland	
 Baltimore	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	oval from State ceme	etery, crem	sition (Name of atory or other place Cemetery	1/22/		20c. Location - City or Baltimore	Town, State e, Maryland
Balti	permit. Departr Imports any inji		21. Signature/of Fune/al Service Licenses	-	D 22	Name and Addres uda-Ruck 922 Wise	s of Facility Funeral I Ave. Du	Home of ndalk, h	Dundalk, I Maryland	nc. 21222
	2000 N		23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau	ons that caused the death. Duse on each line.	o not ente		g, such as cardiac o			Approximate Interval Between
	Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence		Cance				Onset and Death
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1	ted nsit	Examiner	if any, leading to immediate	Due to (or as a consequence	e of):					
524	be executed sician and burlal-transit	cal Exa	that initiated events c. — resulting in death) Last	Due to (or as a consequence	e of):					
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Box 68	ath certifi attending for use a	<u> </u>	in the past 12 months?	yes, outcome of pregnancy Live Birth 2 Fetal de Pregnant at time of deat		Ectopic pregnancy Other (specify)	y		23d. Date of de Month	livery Day Year
. B.	the dea by the a ached	hysic	1 ☐ Yes 2 ☐ WNo 9 ☐ Unknown 9	Unknown		Other (specify)		1		,
Js, P.	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	ed by F	Part II. Other significant conditions contribu	ting to death but not resultin	ig in the ur	nderlying cause give	en in Part I.		acco use contribute to es 2 □ No 3 □ P	the cause of death?
/el	e law rec e has bee ge 2 sho	Completed by						24a. Was ar autops perform	v prior to	topsy findings available completion of cause of
I R R	ian: Th rtificate ctor, pa	Be Co	25. Was case referred to medical examiner?			26. Pla	ice of Death (Check	perform 1 Yes 2 only one)	No 1 ☐ Yes	s 2 🗆 No
₹ ک	Physic this ce	유	1 ☐ Yes 2 No	1 ☐ Inpatient 2 ☐ ER/	Outpatient	3 DOA Othe	4 ☐ Nursing Hor		nce 6 Other (Spec	ify)
36	eath. ir: After ne fune	Certificate:	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year)	injury	work?		od. Describe no	w Injury occurred	
Division	al or Atte s after de l Directo		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	Be. Place of Injury - At home, building, etc. (Specify)	farm, stre	et, factory, office	2	8f. Location (Str City or Town	eet and Number or Ru State)	ral Route Number,
(x)_	n 24 hour n 24 hour e Funera	Medical	(Check 2 Medical Examiner: O	To the best of my knowledg n the basis of examination and ctioner: To the best of my kno	d/or investi	gation, in my opinior	n, death occurred at	the time, date and	place, and due to the	cause(s) and manner stated.
	To the virthing of the complex		29b. Signature and title of certifier	< h		29c. License	number 57-22		od. Date signed (Mont)	n, Day, Year)
	•		30. Name and address of person who comple	eted cause of death (Item 23a	a) (Type, Pr				7,01	
8			Fermin Bar	sted cause of death (Item 23s	: Mrs	560 UF	per che	sapeake	Drive Bel	Air, MD 21014
7	Stat Registra	e ar	11. Date filed (Month Par Year) 2011	Constraints Signature	par	les .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Burlock Judith Ann 8:40P M Jan 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Dunda1k Baltimore 4130 Beachwood Road 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours (Month, Day, Year, **Director** 66 212-44-1844 Maryland 1944 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County event, the Medical Examiner must be notified at Director 10c City, Town or Location 10d. Inside City Limits Dundalk 1 Yes 2 X No MD Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 4130 Beachwood Road United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Rlack. White, etc. þ 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 If Yes Give 1 Yes 2 X No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 12 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Thelma M. Meyers George F. Martin, Sr. other traumatic 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4130 Beachwood Road Dundalk, MD Mr. Joseph A. Burlock 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1/15/2011 injury or 1X Burial 2 Cremation 3 Removal from State Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Sacred Ht. of Jesus Cem. uneral Service Licen Duda-Ruck Funeral Home of Dundalk, any 21222 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Glioblastoma month Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence or). the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Dav Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? Hypertensian 24a. Was an 24 hours after death.

Funeral Director: After this certificate has autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home 5 \(\mathbb{R}\) Residence 6 \(\sum \) Other (Specify) 2 XV0 1 Tes 임 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 1. Natural 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 01/13/2011 0055 Do 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore LGallo DO Holabird Ave Deborah 730

State Registrar Year)

32/Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 28a per me g912 2-24-11 vt

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First Middle, Last) 3. Time of Death Month **Physician** Bayne 559 14 201 tarri anilar /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital Baltimore City If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 X M 2 F 17 218-39-5155 Sept. 21,1993 Maryland Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🕱 No Director MD Baltimore Dunda1k 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 21222 United States 915 Wise Ave. by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√√ No Specify 3 Widowed 4 Divorced Specify White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Years Student N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Linda M. Prettyman Harry L. Bayne, II ၀ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 915 Wise Ave. Dundalk, Maryland Linda M. Cuglar (Mother) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gdns of Faith Cem. :1/19/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222 Ro 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ard oc /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner burial-transit requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician Box 68760. Physician/Medical as the IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Yea Pregnant at time of death 5 Other (specify) 2 No P.O. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>\$</u> 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No has page certificate the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 XYes 2 ☐ No Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director; After this funeral 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 28a. Date of Injury
(Month, Day Year) Certification: 5 Pending investigation Injury 1
Natural 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 2 No heroine ingestion 281. Location (Street and Number of Rural Route Number, 1 🗌 Yes 2 Accident filled in by the 3 Suicide Could not be determined 4 Homicide City or, Town, State) Kirkleich 1851dence 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the dause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 1-14-2011 ddress of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Mor State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene. For State Registra Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year 10:12P^M Yvonne Gallant Conlon 20. 2011 Ja<u>nuary</u> 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 300 South Camp Meade Road Linthicum Anne Arundel If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min 1 D M 20 F 88 Dec 19. 1922 Canada Usual Residence of Decedent 10a State 10h. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐Yes 2 ☐ No Anne Arundel Linthicum Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 South Camp Meade Road 21090 **USA** 12. Was Decedent Ever in U.S.
Armed Forces?
1 ⊠Yes 2 □ No
1 Yes, Give
Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify Specify: White 3 ☐ Widowed 4 🕅 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher <u>High School</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Gallant Eva LaRouche 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis Conlon, Son 300 South Camp Meade Road Linthicum, MD 21090 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 ☐Other (Specify) Baltimore, Maryland Metro Crematory Inc.: 01/21/11 22. Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 21. Signature of Funeral Service Licensee Thomas Gregor homa 23a. Part 1. Enter the disease, or of implications this caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Reseate Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 1 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

the attending physician and hed for use as the burial-tran signed by t Completed page 2 should After this certificate

Division of Vital Records, P.O. Box 68760,

Physician

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Maryland 21215-0036

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If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Worldon Event minst be notified at

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Physician

/Medical

Examiner

Certification: To

To the Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death Funeral Director: within 2. 1011

State Registra

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

141

0020040

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	or 28	Ei.	Maryland Howard 10e. Street and Number	Columbi	La 10f. Zip Code	10a.	. Citizen of What Country?	_
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b	filed all Hyg		17. Father's Name (First, Middle, Last)			Name (First, Middle, Maid	den Surname)	
ylai	ld be Ments arked atic e	잍	Boleslaw	Cwalina		Teofila	Golanska	_
Maryland 21215-0036	permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	- 18	19a. Informant's Name/Relationship (Type, Print)	19b. Mailii	ng Address (Street and Number or	Rural Route Number, City	y or Town, State, Zip Code)	
e, N	and 2 Health em 2: ther t		Robert B. Cwalina Son 20a. Method of Disposition	20b. Place of Dispo	Overcrest Road	Towson, M	aryland 21286 c. Location - City or Town, State	
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transif	Medical	(Check 2 Medical Examiner: On the basis of	examination and/or inves	tigation, in my opinion, death occur	red at the time, date and pl	lace, and due to the cause(s) and manner state	ed.
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	10		30. Name and address of person who completed cause of				11.	_
	1-		Laura Patel 6701		ups St Suite	: 4105 B	altimore, MD 21204	r I
6	Stat Registra		31. Date filed (Month, Day, Year) JAN 2 1 2011 Jan 2 1 2011	trar's Signature				
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Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces? 1 Yes, Sive Year or Dates.	No	Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 ☒No	, Mexican, Puerto R	ify Yes or No- iican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
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Baltimore,	rmit. F partm porta y injui		21. Signature of Funeral Service Licensee	2:	2. Name and Address	of Facility Haig	ht Funer	al Home &	Chape1
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ر او او	sate be executed physician and the burial-transit	edical Examiner	causé. Enter Underlying Cause (Disease or iinjury that initiated events	a consequence of):					
Division of Vital Records, P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	2 ☐ Fetal death 3 ☐	☐ Ectopic pregnancy☐ Other (specify)			23d. Date of delive Month	ery Day Year
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death CIAMPA Physician/ JesSIP Medical 4b. City, Town, or Location of Death 21044 4a. Facility Name (if not institution, give street and number) County of Death **Examiner** Codar LN. Columbia, County General Hospital 5755 If Under 1 Year If Under 24 Hrs. Social Security Number (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 213-80-2098 1 - M 2 -F Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director MD Ellicott City Howard 1 Yes 2 1 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3004 North Ridge Road H305 21043 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Completed by Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced White Year or Dates id Mental Hygiene. marked other than "natur imatic event, the Medical ! 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Alfredo Scellini Maria Barone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Joseph L. Ciampa (Son) 4855 Cherry Tree Lane, Sykesville, MD 21784 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lake View Mem. Park 1/20/2011 Sykesville, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Licenses 100764 PO Box 195 Sykesville. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of attending physician and for use as the burial-transi Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 2 No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certified D30641 Rame and address of person who completed cause of death (Item 23a) (Type, Print)
Rame (h Sabapaln 201-109 Back River N&CIC 12 Day, Year)
1 201 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

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89 X	th cert tendir or use	ian/I	23b. Was decedent pregnant in the past 12 months?		Birth 2 🗌 I	Fetal death 3			/			230	d. Date of del		
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2	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director After this certificate has completed filled in by the funeral director, page 2 s	Medical	29a. Certifier 1 Certifying Ph	ysician: To the b	est of my kn	owledge, death o	ccured at	the time,	date and p	lace, and	d due to the cau	se(s) and m	nanner as sta	ated.	
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	•		30. Name and address of person who	completed caus	e of death (I	tem 23a) (Type, P	rint)	/UU:	37,	<u>-0</u>		1	111	7.1	
1			2835	Smith	Aul	Bile	trus	e 10	M ()	7	1209	5	Min	407	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DENISE JEAN CROSBY JAMUARY 17° 2011 17:03 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death UPPER CHESAPEAKE MEDICAL CENTER BEL HARFORD 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** Birthplace (State or Foreign Country) 1 M 2 Tx F Months Days Hours Min. OCHonth, Pay, Yang 57 53 Director MD 212-70-9362 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD HARFORD ABINGDON 1 Tes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3386 GARRISON CR. 21009 USA "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 √ No Specify: 3 Widowed 4 Divorced Specify: WHITE event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 12 Elementary/Seconday (0-12) College (1-4 or 5+) CASHIER RETAIL is marked other Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BENTON GRIMM ARLENE KUNTZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra APRIL CROSBY-DAUGHTER 11 SHANNON DR BEL AIR, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State PARKWOOD CEMETERY 1/21/11 BALTIMORE, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC 6415 BELAIR RD BALTIMORE, MD 21206 or complifications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest st only one cause on each line. 23a. Part 1. Enter the disease, or co shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Fixal Pulmonary Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** eumothorax Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner the attending physician and the for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of resulting in death) Last Mknow Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ 1 Live Birth
4 Pregnant a in the past 12 months?
1 ☐ Yes 2 ☐No
9 ☐ Unknown Month Pregnant at time of death Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe 1 Yes 1 Yes 2 No 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending Accident
Suicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, within 24 hours a To the Funeral D Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D0065421 January, 18, 2011 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Upper Chesapeake Drive, Bel Air, Maryland 21014 Christa R. Fistlerino 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 21 2011 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year CADDEN NANDA ANUARY Medical 201 5:4 4a. Facility Name (if not institution, give street and number) Examiner 4b City Town or Location of Death 4c. County of Death JOHN'S HOPKINS N/A BAYVIEW MEDICAL BALTIMORE CENTE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🖼 F Months Hours Min Feb. 16, 1946 Director Virginia 212-44-3395 64 Usual Residence of Decedent show 10b. County 10a. State IId be filed within 72 hours after death with the Maryland Mental Hygiene. Examiner must be notified at 10c. City. Town or Location Director 10d. Inside City Limits 28a-f 1X Yes 2 ☐ No MD N/A Baltimore City ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21224 7306 Conley Street United States 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 0 Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: "natural", If Yes, Give Year or Dates 3 Divorced 4 Divorced Specify Completed White event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Years 12 Years Retail Wholesale Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Wayne C. Taylor Maggie Lucille Blevins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Mr. John T. Cadden (Husband) 21224 7306 Conley Street Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 1/18/2011 Parkwood Cemetery Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signatur Joy uneral Service Licensee Duda ankades funeral Home of Dundalk, 21222 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the dis ie, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause on each line. Approximate shock, or heart fe Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) HOUK Medical Due to (or as a consequence of) **Examiner** WEEK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and Exam burial-transi Cause (Disease or linjury cirrhosis YEARS that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) Dav Year Pregnant at time of death pac been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autopsy performed? Yes 2 No 2 No __ Yes 1 Yes 25. Was case referred to medical director. Be 26. Place of Death (Check only one) examiner? မ 2 🗹 No Other: 1 🗹 Inpatient 2 🗆 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 Tyes 2 🗆 No Investigation Suicide Could not be

Division of Vital Records, P.O. Box 68760

completed filled in by the within 2 To the I

Registrar

DHMH 17 Rev 7/2009

State

Medical

4 Homicide

only one) 29b. Signature and title of certifie

29a. Certifier

PORTO CARREIRO 31. Date filed (Month, Day, Year) FERNANDA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

determined

32. Pagistrar's Signature

4940 EASTERN AVENUE BALTIMORE, MD 21224

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

RES-000

28f. Location (Street and Number or Rural Route Number

JANUARU

29d. Date signed (Month, Day, Year)

2011

City or Town, State

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amend Item 25 per me, g911,01/21/2011dhb Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Year Ann Gertrude Delozier 645a Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hespitol Baltimore City N/A 8. Date of Birth (Month, Day, Year) Funeral Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Min. 1 □ M 2 😾 F Months Days Hours 58 Yrs Country) Maryland Director 170-44-6991 Nov 15. 1952 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No MD Carroll Finksburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2525 Baltimore Blvd. United States Lot 21048 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces' Black, White, etc. 1 \square Never Married 2 \square Married Completed by 1 Yes 2 No If Yes, Give Know os Delozie, An Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify: 3 Widowed 4 Divorced Specify: WHITE Year or Dates marked other than "natur matic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Department Store 11th grade Permit. Page 1 and 2 should be filed with Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၀ Dorothy Regina Mitchell Francis Lawrence Cardwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheila D. Leisenring / Niece 2525 Baltimore Blvd. Finksburg, MD 21048 Lot 31 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Crematory Inc 01/11/2011 Baltimore, MD 21. Signalure of Funeral Service Licensee Patrik Fleming 22. Name and Address of Facility Cremation Society Of MD 299 Frederick Road, Baltimore 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Intracranial disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Examiner CERTIFICATION APPROVED BY MEJICAL EXAMINER Due to (or as a consequence of) cause, Enter Underlying attending physician and for use as the burial-trans! Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Month Pregnant at time of death Day Year been signed by the 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Nonknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 1 No Yes 2 No 1 Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) examine .

1 X Yes Hospital Other: ၉ 2 10 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manney of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation Director: / 3 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number 1/12/2011 1881915791 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hespul of Bultimore MD 130 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death it's Name (First, Middle, Last) 2. Date of Death Physician/ 1900 PM Medical 4c. County of Death Examiner institution, give street and number) 4b. City, Town, or Location of Death NIA a ltimove 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Unde If Under 24 Hrs. 8. Date of Birth **Funeral** 1 XM 2 □ F Months Hours Min. Country) Director Usual Residence of Decedent show 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Completed by Funeral Director MD 15altimore 1 Xyes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5450 Jonnuil LISA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 X Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify: Specify: Black "natural", 3 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Admin. Social Socility Assistant Electrician lottrarade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ nomas Dates Malinda Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5450 Januil Avenue Baltinlove MD 21215 Irma Jean Dates 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 A Burial 2 Cremation 3 Removal from State 2011 01 WINGS MILLS, MID 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughin C. Greene Fulleral SCIVICES Randailstown MD 21133 - Weity Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart ailure. List only one cause on each line. Immediate Cause Enal Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Other (specify) Month Day Year To the Hospital or Attending Physician: The law requires that the deswithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖟 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 X No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural iniury 5 Pending Investigation 6 Could not be Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiners in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Chec 29c. License number 29d. Date signed (Month. Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

JAN 2 1 2011

completed cause of death (Item 23a) (Typ, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month 14 2011 tunter Januar James 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death None The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) June 9, 2004 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 218-69-5173 6 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tyes 2X No Maryland Anne Arundel Gambrills 10e. Street and Number 10a. Citizen of What Country? 10f. Zip-Code 1004 Jason Court 21054 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 ☐ Married 1 ☐ Yes 2X No If Yes, Give Year or Dates Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Anne Arundel County College (1-4 or 5+) Elementary/Secondary (0-12) Kindergarten Student Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas William Defibaugh, Jr. Samantha Gayle Fuse 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samantha Gayle Fuse/Mother 1004 Jason Court, Gambrills, Maryland 21054 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of West Artificate) Crematory Date 20c. Location - City or Town, State 2011 | 4 ☐ Donation 5 ☐ Other (Specify) Odenton, Maryland 21. Signature of Funeral Service Lig 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113 Will & M00672 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one good in each line. Do not enter the mode of dying such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Tectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death 5 Other (specify) 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 22 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No 2 No 26. Place of Death (Check only one)

Physician /Medical Examiner

1 - For State Registrar

10a. State

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show notified at

ò death with

ed other than "natural", or items 23a o event, the Medical Examiner must be

injury or other traumatic

permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any injury or other tra

Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene. nt: If Item 27 is marked other than "natural", or Ite

Baltimore, Maryland 21215-0036

Director

Funeral

þ

Completed

Be

Examiner

Physician/Medical

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Completed

Be

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Certification:

Medical

29b. Signa

re and title excertifie

address of person

IF FEMALE:

burial-trar and Box 68760, attending physician The law requires that the death certificate be the as use ō of Vital Records, P.O. the þ has page the Hospital or Attending Physician:

Division

death. To the Funeral Director: , completely filled in by the 24 hours a within 2

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? Hospital: Inpatient Other: 4 \sum Nursing Home 1 Yes 2 □ No 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death
1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending investigation Injury Work? 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in the property of the pro 29a. Certifier (check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

f death (Item 23a) (Type, Print)

and manner stated

teted ause

State Registrar

29c. License number

29d. Date signed (Month. Day, Year)

January

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 12^{ay}, 201^ra 2:30 P M Sally E. DePanise Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Annapolis Anne Arundel Medical Center Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex . Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 Days 77 october 8, 1933 New York 049-24-4834 Director Usual Residence of Decedent 28a-f shov 10b. County should be filed within 72 hours after death with the Maryland nand Mental Hyglene. 'r is marked other than "natural", or items 23a or 28a-f sho 'r is marked other than "natural", or items 25a or 28a-f sho 'r is marked other than "natural", event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🗓 No Anne Arundel Odenton Maryland 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral United States 21113 1111 Colony Ridge Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. 3 - Widowed 4 - Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) General Electric Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ruth Griffing Phillips Heinrich Friedrick Gerhard Naber injury or other traumatic Department of Health and Important: If item 27 is many injury or other traumany injury or other traumance. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1111 Colony Ridge Road, Odenton, Maryland 21113 Ambrose DePanise/Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State January 14, cemetery, crematory or other place, West Arundel Crematory 1 Durial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2011 Odenton, Maryland 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113 21. Signature of Funeral Service Licer MO1386 inplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Pall Shock, or ter the disease, or o Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Myocacaca disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to joi as a consequence of oronam that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 the attending phohed for use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year signed by the a 1 ☐ Yes 2 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Volve Regurgitation Records, 1 Yes 2 No 3 Probably 4 Unknown mellitus type I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed' certificate 1 ☐ Yes 2 ☐ No Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 **K**No 1 Tes မ 12 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. 1 Natural 2 Accident 5 Pending 1 Tyes 2 🗌 No Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and D16376 0 MD

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Month Arsala Anna Ewing 18 2011 10:30A^M Medical January 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 🗆 M 2 🗶 F Mary Tand 3/28/1926 Director 219-18-2514 84 Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Baltimore Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9109 01d Harford Road 21234 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 XXNo Black, White, etc. þ 1 Never Married 2 Married within 72 hours after If Yes, Give Year or Dates 1 Yes 2X No Specify: Specify: White 3 🙀 Widowed 4 🗆 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. I other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Pulmportant: If item 27 is many injury or other <u>Seamstress/Sales</u> <u>Hutzler's</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Kraeter ည Mary Fleischman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carroll Meadows Drive Baldwin, Maryland 21013 Mark J. Ewing / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ANUARY 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 1/21/2011 Baltimore, Maryland Sacred Heart Jesus Ruck Towson Funeral Home, Inc. 22. Name and Address of Facility 1050 York Road Towson, Maryland 21204 Approximate 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ **CARDIOMYOPATHY** disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month signed by the 9 Unknown ARSALA EWING Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 X No 1 🗌 Yes 2 No Yes eral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital 2 X No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 27. Manner of Death 28c. Injury at work? 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 Yes 2 | No 2 Accident
3 Suicide
4 Homicide Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check

10

State Registrar

only one 29b. Signature and title of cer

31. Date filed (Month, Day, Year)

JAN 2 1 2011

ess of person who completed cause of death (Item 23a) (Type, Print)

3X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d, Date signed (Month, Day, Year)

MD 21093

TIMONIUM,

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#10e, perFH, G911, 1/21/2010, WS

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lorraine C. Edmonds 2011 6:00 PM √anuary Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Towson Greater Baltimore Medical Center Baltimore 5. Social Security Number 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** 1 🗆 M 2 🛣 F Days Hours Min (Month, Day, 63 214-50-2120 Director MD Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location
Baltimore 10a State 10b. County with the Maryland 10d. Inside City Limits Director MD N/A 1 Yes 2 No 10e. Street and Number Chestnut 10f. Zip Code 10g. Citizen of What Country? 21221 Funeral USA 155 Chestmut St. death v 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give African ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Amer. Completed 3 Widowed 4X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'amy nigury or other traumatic event, the Magone. Elementary/Seconday (0-12) Self College (1-4 or 5+) Home Maker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Pearl Galer Charles Rogers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3811 Mayberry Ave, Balt., MD 21206 Steven K. Alford?Son 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bayview Crematory 20c. Location - City or Town, State Date 1 Burial 2 remation 3 Removal from State 1/21/11 Balt., MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hari P. 21. Signature of Fulleral Service Licensee Close F.Svs, PA 5126 Belair Rd, Balt., MD 21206-5105 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Anner Onset and Death Ph sician/ mo disease or condition resulting in death) 0 Medical Due to (or as a consequent Examiner D en Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. Cause (Disease or iinjury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of) ate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 Yo Month 1 Yes 2 No. 1 Unknown / Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autons perform 1 Yes 2 No Yes 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) GBM C Hospital 1 Yes 2 No Other: 1 Inpatient 2 K ER/Outpatient 3 IDOA Certificate: To 4 Nursing Home 5 Residence Manner of Dea h 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier certifying Physiclan: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my only coursed at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my only coursed at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 006 leted cause of death (Item 23a) (Type, Print) 30. Name and address of person who co WANY 31. Date filed (Month, Day, Year 32. Registrar's State Registrar

11-00449 Brian Ellick

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Certific	ate of	Death			Reg. No.				
Physicia Medical Exami		Decedent's Name (First, Midd							eath Day	Year	3. Time of Death 0247 hrs		
yieulcai Exaiiii	ner	4a. Facility Name (if not institution	Brian	1		D. City, Town, or	Location o		16, 2011	County of De			
		618 47th Street	,	,		Baltimore			Baltimore County				
Funeral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. last bir	thday)	If Under 1 Yea			Birth (MM/DD		Birthplace (State or eign		
Director		215-04-3471	1XM 2F	41	Yrs.	Months Day	s Hours		14,1		Country) MD		
any		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Locatio	- -					10d. Inside City Limits		
			ltimore	i con only, rom			Ltimoı	re Co.			1 Yes 2 No		
faryland	Director	10e. Street and Number				10f. Zip Code			10g. Citizer	n of What Co	ountry?		
ith the M 23a or 2 notified		618 South 47	7th Street				21224	4	Un	ited S	States		
h with	Funeral	11. Marital Status	12. Was Deceden					in? (Specify Yes or Puerto Rican, etc.)	No- 14	I. Race - Am White, etc.	erican Indian, Black,		
er deat				X No		Yes 2X No		Total Tributi, Gran,			White		
hours after death with the Maryland "natural", or items 23a or 28a-f she Examiner must be notified at once	ğ	15. Decedent's Education (Spe	or Dates:	mpleted) 16a.				ind of work done		pecify: d of Busines			
27	Completed	Elementary/Secondary (0-12)			during mo	st of working life	. DO NOT	use retired)		ortgag			
9036 within iene. er the	m d	12 Years	2 Years		Bro	oker				Morga	re_		
215-0036 be filed within 72 ntal Hygiene. rked other than "	Be Co	17. Father's Name (First, Middle						s Name (First, Middl nerine E.					
Z. = = = 1	9	Edward S. E11:		19	b. Mailing	Address (Stree		ber or Rural Route N			ate, Zip Code)		
imore, MD 2 Pages I and 2 shou nent of Health and I lant: If item 27 is n or other traumatic	Ė	Mrs. Catherine	e Ellick(Mot					et Balti					
ore, ME ss 1 and 2 s of Health au If item 27 her traum		20a. Method of Disposition 1 X Burial 2 Cremation	n 3 Removal from St		of Disposit tory or othe	ion (Name of cer er place)	metery,	Date		ation - City	or Town, State		
Baltimore, permit. Pages l ar Department of Hee Important: If ite		4 Donation 5 Other S	pecify:	Oak I		Cemetery		1/20/201			e, Maryland		
Baltimo permit. Page Department of Important:		21. Si n of Funeral ser ice	Ucensee		Due	me and Address da-Ruck	of Facility Fune:	ral Home	of Dun	dalk,	Inc.		
Physician		23a. Part I. Enter the disea. , or		the death. Do no	ot enter the	22 Wise mode of dying,	AVe.	Dundalk ordiac or respiratory	Mary arrest, shock	, or heart	21222 Approximate Interval		
/Medical		failure. List only one cause Immediate Cause (Final disease	W-+L-1-	ne Into	xicat	ion					Between Onset and Death		
_xammer		or condition resulting in death)	Due to (or as a cons	equence of):									
	5	Sequentially list conditions, if any, leading to immediate	b	equence of):							+		
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	c. Due to (or as a cons	equence of):									
uted nd ransit		events resulting in death) Last	d.	equence ory.									
760, icate be executed physician and the burial - transit	/Medical	X UNPENDED	X AMENDED 23	a.27.28a	1-f po	er me g ⁹	913 3- -11 vi	-7-11 v t					
760, ficate be g physic	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcor	me of pregnancy			Ectopic		- 1	Date of delive			
Box 68: death certif	ciar	past 12 months?	4 Pregnant at	Attended to the second	re-men	Ideath 3 [er (Specify)		pregnancy	IVIC	onth	Day Year		
Box 687 ne death certifi the attending hed for use as (Physician		4nown 9 Unknown										
ires that the signed by it is detached	<u>۾</u>	Part II. Other significant condit	ions contributing to deat	h but not resultin	g in the un	derlying cause g	given in Par				to the cause of death?		
ds, equire een sig	Completed										autopsy findings available		
e law requir	ם			·				pe	opsy formed?	death?			
Vital Rec ysician: The I his certificate I director, page		25. Was case referred to medica	-			26.Place	of Death (Check only one)	2 No	1 🗸	Yes 2 No		
Vita hysicia this ce	o Be	examiner? 1 ✔ Yes 2 No	Hospital: 1 Inpatie	ent 2 ER/O	utpatient		0.0	Nursing Home 5	Residence	e 6 🗸 Otr	er: Scene		
ling Ph After i	Ë	27. Manner of Death 1 Natural 5 Report	28a. Date of Inju (Month, Day,Y	ury 28b. 'ear)	Time of Inj	·	ry at Work?		e how injury	occurred			
Sior Attend death ector: by the	catio	Pend	stigation Id 1-16		2:30	am _	res 2 🗶	unk	nown	Number of I	Dural Davida Number City		
Division of Vital Records, P.O. pital or Attending Physician: The law requires that to ours after death. reral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detect	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural or Town, State) 618 47th Baltimore, Md. 2122									th Street		
E 8 5	_	20a Cartifier	Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
To the Hos within 24 h To the Fun completely	Medical		miner: On the basis of exa and manner stated.	mination and/or i	nvestigatio	n, in my opinion	, death occ	urred at the time, da	te and place,	and due to	the cause(s)		
	Σ	29b. Signature and title of certifie	n. d.	0 -		29c. Licenso					lonth, Day, Year)		
		Wengenie	. Ine Us	UL		0.C.1	vi.⊏.		Janua	iry 16, 20			
		 Name and address of person Margarita Korell MD. 	Assistant Medical		900 W.	Baltimore St	reet, Ba	ltimore, MD 212	223				
		31. Date filed (Month, Day, Year)	2. Registra		barks		_						
Regist	rar	JANGI	Ull Jensus	1 pl. 19	S. S. S. S. C.								

11-00505

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

John W. Fossler State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Day January 17, 2011 Medical Examine John W. Fossler 0015 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Agnes Hospital N/A5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Funeral Foreign Days Months Hours Director Country Maryland 216-01-2525 1 X M 2 F 94 July 6 Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

The portant: If item 27 is marked other than "nature." MD **Baltimore** 1 Yes 2 X No Catonsville Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Bristol Hill Court, Unit 2 21228 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married White, etc. 1 X Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: WW II Specify: White Þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 2 Meat Producer Manager 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Charles W. Fossler Margaret Simmer1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria O. Fossler, wife Bristol Hill Ct. Unit 2 Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State Loudon Park Cemetery 01/21/11 Baltimore, MD Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George MacNabb MacNabb Funeral Home, P.A. Frederick Road Catonsville 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hea Physician Approximate Interval failure. List only one cause on each line Between Onset and Medical a. Head Injuries Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause Due to (or as a consequence of): events resulting in death) Last and transi Physician/Medical signed by the attending physician is be detached for use as the burial -UNPENDED AMENDED Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy Day Year past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed? death? certificate ✓ Yes 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital examiner? Hospitał: 1 ✓ Inpatient 2 ER/Outpatient 3 DOA Other₄ Nursing Home 5 Residence 6 Other this 1 🗸 Yes 2 No 28a. Date of Injury FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 Natural Probable fall FOUND Director: d in by the f Pending 1 Yes 2 V No 2 🗸 Accident Jan 3, 2010 0910 hrs Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 1 Bristol Hill Court, Catonsville, MD determined (Specify) Single Family Home Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 20, 2011 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month

DHMH 17 Rev 1/2001 **OCME 2006**

Registra

2. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar Ce	rtificate of Death	Re	g. No.	
	Physicia Medic		Decedent's Name (First, Middle, Last) Richard George	Flynn	2. Date of Death Month January	Day Year 20,2011 3:10	
	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
1			Anne Arundel Medical Center	Annapolis		Anne Arundel	
Ī	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 578-42-2706 12 M 2 G F 78	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	9. Birthplace (State or Country) NY	Foreign
	3		Usual Residence of Decedent		1 007 037	1752 112	
	and sho	ō	10a. State 10b. County 10c. City, Town or Le	ocation		10d. Inside City	y Limits
	laryl 8a-f tifiec	Director	MD Queen Anne's	Chester		1 🛣 Yes	2 🗆 No
	or 23	۵	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?	
	with t s 23a ust be	Funeral	5008 Bridgepointe Drive	21619		USA	
	eath tem: erm	Fur	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - American Indian,	
5-0036	filed within 72 hours after death with the Maryland Hygiene. 44 Hygiene. 45 either than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	nican, etc.)	Black, White, etc. Specify: White	
<u>က်</u>	2 hour "natur edical	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work	ding 1	6b. Kind of Business Industry	
1212	within i		Elementary/Seconday (0-12) College (1-4 or 5+)	Florist		Retail	
ğ	iled v	Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, Ma		
ylar	should be file and Mental is marked of raumatic eve	오	Howard Flynn	Gl	adys E	rickson	
	of Health and Ment of Health and Ment fitem 27 is marked r other traumatic e			ng Address (Street and Number or Rur 08 Bridgepointe			19
baltimore,	je 1 an it of H if itel or oth	Ц	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposerery, cre	osition (Name of matory or other place)	Date 20	Oc. Location - City or Town, State	
	it. Pag ntmen rtant riury			ırney Crem. 1/24/	2011	Woodbine, MD	
Ra	permit. Page 1 Department of Important: If it any injury or c		21. Signature of Funeral Service License Dorota Marshall	 Name and Address of Facility Maryland Crema PO Box 1413, 	ation Se Baltimor	rvices e. MD 21203	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.				
	nysician/	F 34		RIN must	Awat	Onset and Re	eart
	Medical Examiner		resulting in death) Due to (or as a consequence of):		1 0 1		
	n #	Examiner	Sequentially list conditions, b. Due to (or as a poner, terrine c) cause. Enter Underlying				
	e death certificate be executed the attending physician and hed for use as the burial-transit	xau	Cause (Disease or linjury that initiated events resulting in death) Last				
) -	be ex sician burial		d d				
09/90	cate g phy s the	/Medical	_ u				
8	nding use a		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	7		23d. Date of delivery	
POX	death	Physiciar	1 1 163 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Other (specify)		Month Day Ye	ear
5	of the		9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I	an- Dida-t-	cco use contribute to the cause of dea	-11-0
ν, Γ	To the propriat or Attending Priysician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	d by	HMPERCALCIEMIA	and onlying saddo given in rait i.	1 \(\text{Yes}	2 No 3 Probably 4 DU	
סבס	s beer	olete			24a. Was an	24b. Were autopsy findings av	
Records,	ine iav ate has bage 2	Completed			autopsy performe 1 \sum Yes 2	prior to completion of cau death?	use of
<u> </u>	rtifica	Be (25. Was case referred to medical examiner?	26. Place of Death (Chec		1 100 2	-
VICAL	ysic is ce direc	일	1 Yes 2 No Hospital: 1 Copatient 2 ER/Outpatie	nt 3 DOA Other: 4 Nursing He	ome 5 🗆 Residenc	be 6 Other (Specify)	
5	ng Pro		27. Manper of Death 1 → Netural 5 □ Pending		28d. Describe how		
ם ו	earth. or: Af he fu	fica	2 Accident Investigation	M 1 ☐ Yes 2 ☐ No			
DIVISION	or Att	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number State)	r,
5	spiral hours a neral [29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occured at the time, date and place, ar	nd due to the cause(s) and manner as stated.	
i	in 24 in 24 the Fu	Medical	(Check 2 Medical Examiner: On the basis of examination and/or invest only pre) 2 Certifying Nurse Practioner: To the best of my knowledge,	tigation, in my opinion, death occurred a	t the time, date and p	place, and due to the cause(s) and manr	ner stated,
,	Neith Co.		29b. Signature and title of certifier	29c. Lisense number	290	. Date signed (Month, Day, Year)	
			o rek wall w	D (0 70	1 0	11121111	
\			30 Name and address of person who completed cabee of death (Item 23a) (Type, Item 23a) (Type, Item 23a) (Type, Item 23a)	DICAL PRUM	210 A	unapour una	214-01
	Stat	е	31. Date filed (Month, Dex Yor) 2011 33 Registrar's Signature	a Ked	·		

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Ma	aryland				Mental Hy	giene		01095
	***		Registrar 1. Decedent's Name (First, Middle, L	ast)		Cer	tificate of l	Jeath	2. Date of De	Reg. No.	-	3. Time of Death
	Physicia		Antoi		nica	Frazie	r		Month Jan 19	Day	Year	06:45 AM
	Medic Examin		4a. Facility Name (if not institution, gi				4b. City, Town, o	r Location of Death			nty of Death	
)		8500 Mike Shapiro	Drive # 219			Cli	nton			ince Geo	
	Funeral			Sex 7. Age		st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir		9. Birth	place (State or Foreign
ų.	Director			1 □ M 2 XXF	67	Yrs.	Michael Bays	110010	July 28	, 1943	Wast	nington DC
	nd how at	٦ ا	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	eation					10d. Inside City Limits
	laryla la-fs ified	Director	Maryland Prince	George's		Cli	nton					1 Yes 2 No
	or 28 e not	흐	10e. Street and Number	300180 5		CL.	10f. Zip Code			10g. Citizen	of What Cou	
	with s 23a ust b	Funeral	8500 Mike Shap	iro Drive # 2	19		20735			Unite	d State	es .
	death items ier m	Fun	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	. 13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Sp	pecify Yes or No-		lace - Ameri	
36	after (", or camir	by	1 Never Married 2 Married	1 Yes 2XX	No		Yes 2 No		o i libali, bibi,		Black, White, in Afric a	n American
21215-0036	72 hours after death with the Maryland "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	Completed	3 X Widowed 4 ☐ Divorced 15. Decedent's	Year or Dates.			ent's Usual Occup					
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	be filed ental Hyy ked oth ic event	o Be	17. Father's Name (First, Middle, Last)				18. Mother's Nar	,	Maiden Surna	ıme)	•
yla	ild be Ment narke natic	ပ	Leroy Miller					Wilh	elmina 1	Miller_		
Maryland	2 should the lith and Me 27 is mark	1	19a. Informant's Name/Relationship Robin Butler (Dan	, ,	1	1	g Address (Street			-	, State, Zip	Code)
	and and Healt		20a. Method of Disposition	igitter)	20h Pi		Kaine Driv	e, Clinton	Date	20c. Locatio	n City or T	own State
nor	Page 1 nent of ant: If it		1 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Removal from State	_ ce	metery, cren	natory or other plac				•	
Baltimore,	+ P T =	1 8	21. Signature of Funer I Service Lice		101		In Cemetery . Name and Addre		25, 2011		ntwood,	MD ld Alexandria
ñ	Depart Depart Import any ir	8 0	Louis L. An	and moos	257	1	Ferry Road,	Clinton,	MD 20735	none, unc	0033 (id Alexandria
			23a. Part 1. Enter the disease, or conshock, or heart failure. List only							rest,		Approximate Interval Between
	Physician/	8	Immediate Cause (Final disease or condition	Find	57	Large	· Line	00	5 sear	30		Onset and Death
	Medical Examiner	ijij	resulting in death)	Due to (or as a	conseque	enc :						
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R.	execut n and al-tra	Еха	that initiated events resulting in death) Last	C. Due to (or as a	conseque	ence of):						
260	icate be executed physician and s the burial-transit	edical		d								
876	tificat ng ph as th		IF FEMALE:									
Box 68	th cer ttendi or use	ian/	23b. Was decedent pregnant	23c. If yes, outcome of	2 🗌 Fetal	death 3	Ectopic pregnanc	у			Date of deliv	
Bo	e dea the at hed fo	Physician/M	in the past 12 months? 1 ☐ Yes 2 █ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of de	eath 5∟	Other (specify) _				Month	Day Year
Ö.	requires that the death certific been signed by the attending should be detached for use as	y Ph	Part II. Other significant conditions	contributing to death b	ut not resu	Iting in the u	nderlying cause gi	en in Part I.	23e. Did t	obacco use co	ntribute to t	he cause of death?
S,	ires t sign	ed by							1 🗆	Yes 2 No	3 Pro	bably 4 🗆 Unknown
ord	v requ	Completed							24a. Was		b. Were auto	psy findings available
3ec	Physician: The law this certificate has al director, page 2	lmo							auto	ormed? 2 No	death?	ompletion of cause of
a	ian; T	Be C	25. Was case referred to medical examiner?				26. PI	ace of Death (Chec		2 2 110	1 🗆 163	2 🗆 140
₹	hysic nis ce I direc	10	1 ☐ Yes 2 🛣 No	Hospital:	ent 2 🗆 E	R/Outpatien	t 3 🗆 DOA Oth	er: 4 🗌 Nursing H	lome 5. Resid	dence 6 🗆 O	ther (Specif)
o c	or Attending Ph after death. Director: After thi I in by the funeral	ate:	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of injur (Month, Day		28b. Time of injury	28c. Injun work	?	28d. Describe h	now injury occi	urred	
sior	ttend death stor: / the 1	Certificate:	2 Accident Investigati 3 Suicide 6 Could not	be 380 Place of Inju	n/ At bon	no form otro		Yes 2 □ No	0.06 4: //	24	-h-u-u-Dum	/ Double Aliverture
Division of Vital Records, P.O.	l or A after Direc	Cer	4 Homicide determine	28e. Place of Inju building, etc	. (Specify)	ne, iarm, sire	et, factory, office		City or Tov		nber or Hura	l Route Number,
	To the Hospital or Attending Physician; The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Medical		ysician: To the best of								
	he Ho iin 24 he Fu	Med		rse Practioner: To he i	nest of my	knowledge d	eath occurred at th	e time date and pla	ice and due to th	e cause(s) and	manner as si	use(s) and manner stated. ated.
	North To 1		29b. Signature and title of certifier	and to be	2	_	29c. License	number	, [29d. Date sign	ned (Month,	Day, Year)
P	,						1)00	1010	_	01-0	41-	2011
	6		30. Name and address of person who IVAW ZAMUK K	zompleted cause of de 920	eath (Item 2	23a) (Type, P 481L	CT 5	TE 200,	LARG	ON	1D 6	6774
	Stat Registra	e ar	31. Date filed (Month, Day, Year) JAN 21 2011	32. Registra	r's Signatu	ire de la constitución de la con						Day, Year) 2011 20774

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19a per fh g911 1-26-11 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FARZANFAR ATEFEH Year Month Day M 11-02 PM JAN Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Howard Columbia Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth January 25,1936 Birthplace (State or Foreign Country)
 Tran **Funeral** 1 □ M 2 **X**F Months Days Hours **Director** 214-50-0422 74 Iran Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Howard Ellicott City 1 ☐ Yes 2 XX No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Completed by Funeral 3449 Tyler Dr. 21042 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. 1 Never Married 2 X Married If Yes Give 1 ☐ Yes 2 X No Specify: 3 Divorced Specify: white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Javad Mobargha Hamdam (unknown) 19a. Informant's Name/Relationship (Type, Print)
Susan Silverman/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3203 Clumpgrass Cove Austin, TX 78735 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem GardJan. 19,2011 Timonium, Maryland 21. Signature of Funeral Service Licenses John O. Mitcheil IV, Funeral Services of Dulaney Valley 200 E. Padonia Rd. Timonium. MD 21093 P.A. 200 E. Padonia Rd. Timonium, MD 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any conditions, cause. Enter Underlying Cause (Disease or linjury Examine Dur to for an a nonsequence of Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Day 4 Pregnant at time of death 9 Unknown Month Year signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RESPIRATORY FAILURE ACUTE RENAL cate has been sig page 2 should b 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown FAILURE, DIABETES 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 24 hours after deam.

Funeral Director: After this certificate I 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🖪 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MD 10062634 JAN 15, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MATISIEN AWAN 10796 HICKURY RIDGE RD CILUMBIA MO

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JAN 21

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Falkenhan, Sr. William Month Henry 2011 Jan. 7:45 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 21 Leeway Baltimore Co. Dunda1k 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F Months Days Year) Hours Mary land **Director** 215-09-4820 91 Vrs April 11, 1919 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits **Funeral Director** 1 ☐ Yes 2¾XNo MD Baltimore Dunda1k 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21 Leeway 21222 United States 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 M Yes 2 □ No If Yes, Give Year or Dates. WWII Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify. White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Baltimore County life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Firefighter Fire Department 8 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Katie May Davis Casper Joseph Falkenhan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mary Catherine Falkenhan Dundalk, Maryland 21222 Leeway 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 1/15/2011 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery Baltimore, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final husician/ MELLITUS disease or condition Medical resulting in death) nsequence of): Examiner ETLIENSIN Sequentially list conditions Examine rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ ZUBITUS Completed 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy his certificate h Il director, page performe 1 Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 5 Hesidence 6 Other (Specify, ပ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA this in 24 hours after uses... he Funeral Director: After the inleted filled in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Vatural 5 Pending work? Accident 1 🗌 Yes 2 🗌 No Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1. Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 within 2 To the F only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

30. Name and address of person

31. Date filed (Month,

nth, Day, Year)

1 2011

1-11-2011

an

who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month AWRENCE 2011 15:50 FRAZIER JANUARY 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death BALTIMORE & N/A Johns HOPKINS BAYULEW MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
May 30, 1916 9. Birthplace (State or Foreign West Virginia Months Days Hours t√2 M 2 □ F 236-16-0209 94 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7428 School Lane 21222 United States 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 27 No White s/Industry ustry Zip Code) 21222

29d. Date signed (Month, Day, Year)

Re Completed 2

Director

Physician

Examiner

Funeral

Director

/Medical

For State Registrar

10a. State

MD

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Franke.

Physician /Medical Examiner

Certification: To Be Completed by Physician/Medical Examiner burial-tran attending physician for use as the buria led by the a nis certificate has been signed director, page 2 should be det within 24 hours after death.

To the Funeral Director: After this certificate to completely filled in by the funeral director, page

29b. Signature and title of certifier

29a. Certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print)

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

ā	/428 School Lane	9		21222	United States					
to be completed by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.s Armed Forces? 1	S.	13. Was Decedent o If Yes, specify Co		Specify Yes or No- rto Rican, etc.)		14. Race - Am Black, Wh	ite, etc.	
	3 ¥ Widowed 4 □ Divorced 15. Decedent's Edu	Year or Dates:	16a.	Decedent's Usual Occ	upation		16b. Ki	ind of Busines	White	
5	(Specify only highest grad	de completed)		(Give kind of work dor life. DO NOT use reti	e during most of wo	orking		o made ay		
5	Elementary/Secondary (0-12) 12 Years	College (1-4or 5+)	Welder					Steel Industry		
3	17. Father's Name (First, Middle, Last)					me (First, Middle,	Maiden	Surname)		
2	Okey Frazier				Nora V	Vorkman				
	19a. Informant's Name/Relationship (7)	' .' .	19b.	Mailing Address (Stre	et and Number or F	Rural Route Numbe	r, City o	or Town, State,	Zip Code)	
	Mr. Kenneth Frazi	er (Son)	34	01 Wallfor	d Drive	Dundalk,	Ma	ryland	21222	
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	emetery	Disposition (Name of y, crematory or other p	rial Park		Dor		aryland	
	21. Signature of Funeral Service Licens	/see		│ 7922 Wis	ress of Facility K Funeral E Ave. Di	undalk, N	lary	dalk, l land 2	Inc. 21222	
	23s Part 1. Enter the disease of complishock, or heart failure sist only of	lications that caused the death	. Do n	ot enter the mode of d	ying, such as cardia	ac or respiratory ar	rest,		Approximate Interval Between	
4	mmediate Cause (Final	Reseins Tan	F	AILURE					Onset and Death	
	resulting in death)	Due to (or as a consequ	ence o	7 2 2 7 2 7					26 hours	
		Parimini		-,-					Solve	
	Sequentially list conditions,	Duc to (or as a consequ	iance d	f):						
1	cause. Enter Underlying Cause (Disease or injury that initiated events									
	resulting in death) Last	Due to (or as a consequent	ence o	f):				-		
1	in return		_				- 1			
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnal 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	death	3 ☐ Ectopic pregna 5 ☐ Other (specify)				23d. Date of de Month	elivery Day Year	
	Part II. Other significant conditions con	ntributing to death but not resu	Iting in	the underlying cause of	iven in Part I.	23e. Did to	bacco u	use contribute	to the cause of death?	
						1 □ Y	e <i>s</i> 2[□No 3□F	Probably 4 Unknown	
						24a. Was a autop: perfor 1 □ Yes	SV	death?	utopsy findings available completion of cause of successions 2 \sumsetmess No	
1	25. Was case referred to medical examiner?					ath (Check only or	ne)			
,	I les 2 DAO	lospital: 14☐Inpatient 2☐I		patient 3 DOA		Home 5 Resid	ence (6 □Other (Sp	ecify)	
	27. Manner	28a. Date of Injury (Month, Day, Year)	28b. Ti Inj	jury W	uryat ork? ⊒Yes 2 ⊒No	28d. Describe h	ow injur	y occurred		
	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hor building, etc. (Specify	me, farr	m, street, factory, office		28f. Location (S City or Town	treet an n, State	d Number or F	Rural Route Number,	

State

Medical

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

			Plea									II Copie			ible.		
	_	For State		S	tate of N	Marylan		epartme Ce <i>rtifica</i>			and IV	lental Hy	giene Reg. N	A 25	g g	rinea	
DI		Registrar 1. Decedent's Name	e (First, Middle,	Last)					10 07 2	Journ		2. Date of De	ath D		Year .	3. Time of Death	
Physicia Medic	al	4a. Facility Name (if	Fre		t and number	4	Gu	idry	tv. Town, or	Location	of Death	Januar		$1^{9}8$,	201		
Examin	er	1517 L				,			ıltim		O Death	NA NA					
Funeral Director		5. Social Security No. 217 - 22 -		6. Sex 1	2X F 7. /	Age (In yrs. I 84	ast birthd Yr	Month	er 1 Year s Days	If Under Hours	Min.	8. Date of Bir (Month Da	th iv, Year) – 2 (6	9. Birth Cou	pplace (State or Foreigr ntry) MD	7
nd how at	'n	Usual Residence of 10a. State	Decedent 10b. County			10c. Cit	y, Town c	or Location								10d. Inside City Limits	
Maryla 28a -f s otified	Director	MD	N	A		В	alti	imore								1 Yes 2 No	D
vith the 23a or st be n	ralD	10e. Street and Nun		de A	venue				Zip Code 2121	8			10g. C	itizen of \USA	What Cou	intry?	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inportant: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral	11. Marital Status 1 Never Marr 3 Widowed	ied 2 🗆 Marr	12.	Was Deceder Armed Forces 1 Yes 2 If Yes, Give Year or Dates	nt Ever in U.: s? XNo	S.	13. Was Dec	edent of H	ispanic Or an, Mexica	n, Puerto	cify Yes or No- Rican, etc.)		14. Rac Blac	k, White	can Indian, etcAfrican erican	
nin 72 hours te. han "natur e Medical E	Completed	(Spe	15. Deceder cify only highe onday (0-12)	nt's Educat st grade c	tion ompleted) College (1-4 c		(C	Decedent's Us Give kind of v fe. DO NOT	vork done (use retired)	ation during mos	st of work	ing	St		Hie	hway	
ed with Hygier other t ent, th	d)	12th G 17. Father's Name (4yrs.		AC	ccoun	tant	18. Moth	ner's Nam	e (First, Middle,	•			ation	_
d be fil Mental arked atic ev	욘	James	Ε.	Lew	is						ara		Lew				_
2 shoul th and I 27 is ma trauma		19a. Informant's Na			•							al Route Numbe				Code) 0 21218	
1 and of Heall item 2		Tamarr 20a. Method of Disp	position			20h I	Place of F	Disposition (A	lame of	- 1		Date	20c.			Town, State	
. Page tment c tant: If jury or		1 🔀 Burial 2 4 ☐ Donation	5 Other (S	(pecify)	noval from Sta	ate A	rbut	crematory o				-22-11		rbu			
permit Depar Impor any in		21. Signature of Fu	neral Service L	icenee	dio				and Addre							me P.A. ,MD 2121	7
Physician/ Medical Examiner	Examiner	23a. Part 1. Enter 1 shock, or hea Immediate Cause disease or condition resulting in death) Sequentially list confirm to include. Enter Under Cause. Enter Under Cause (Disease or	rt failure. List c (Final on	a	Due to (or a	ine. OSCIE as a conseq 21 ENS as a conseq	uence of uence of	Card	20001	ſ	^	or respiratory a	rrest,			Approximate Interval Between Onset and Death	
Attending Physician: The law requires that the death certificate be executed ar death. Actor After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical Exar	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2	s Last		Due o (or : If yes, outcor 1 Live Bir 4 Pregnar	ne of pregnath 2 Fet	uence of		ic pregnan	су	_				ate of deli	ivery Day Year	
at the de d by the etached	Physi	9 Unknown	1		9 Unknow		sulting in	the underlying	na cause ai	iven in Par	t I.	23e Did	tobacco	use conf	tribute to	the cause of death?	_
uires tha n signed ald be d	ed by	- Circlin Outor organ										1 🗆	Yes	2 🗌 No	3 🗌 Pr	obably 4 💆 Unknow	'n
The law requate has bee page 2 short	Completed											24a. Was auto peri 1 \square Yes	opsy ormed?	.	prior to death?	opsy findings available completion of cause of 2 🇖 No	;
sician: The certificate irector, pag	Be C	25. Was case referrence examiner?	red to medical No	Hosp	oital:	ationt 2] EB/Out	patient 3 🗆	Oth	lor:		k only one) ome 5 🛣 Res	idones	6 🗆 O#	er (Speci	(6)	
Attending Physician: er death. ector: After this certific by the funeral director,	ate: To	27. Manner of Deat			28a. Date of		28b. Tii	me of jury	28c. Inju	ry at k?		28d. Describe					
	Certificate:	2 Accident 3 Suicide 4 Homicide	Investi 6	not be	28e. Place of building,	Injury - At h etc. (Specia		m, street, fac		Yes 2	_l No	28f. Location City or To			er or Rur	al Route Number,	
To the Hospital or within 24 hours after To the Funeral Director Completed filled in	Medical	(Check	Certifying	xaminer:	On the basis	of examination	on and/or	investigation,	in my opin	ion, death	occurred a	it the time, date	and pla	ce, and du	ie to the c	cause(s) and manner sta	ited.
To the within 2 To the comple	Ž	only one) 29b. Signature and	Certifying		ractioner: 10	the best of n	ny knowle	-	29c. Licens			ce, and due to t				, Day, Year)	
		15.	lax (7.4	any	MD			D3	322	50		1	19	11		
-		30 Name and add	ress of be son	who comp	M D	of death (Iter	m 23a) (T) 1 3Q	Falls	s Roc	ad	Ba	Himor	Ce,	MD	2	1211	
Sta Registr		31. Date filed (Mon	JAN'2	2011	32. Alegi	istrar's Sign		of and	and a second								

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
AMEND ITEM 2005, c. per FH, 1/28/2011, ws

Certificate of Death

Reg. No. For State Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 9:00 PiLM ames 2011 anuaru Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Sinai Hospital of Baltimore Baltimore Citu Social Security Number (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign Days Min. 1 M 2 🗆 F 12 Hours 6 - 23 -Country) 215-26-7493 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State death with the Maryland . City, Town or Location 10d. Inside City Limits Director MDtonsville Baltimore 1 Yes 2 No 10g. Citizen of What Country? Funeral items 23a 21228 load Gooden USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. "natural", or iter edical Examiner Completed by 1 Never Married 2 Married Yes 2 No Yes, Give within 72 hours after 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT usp retired) James T. (Specify only highest grade completed) econday (0-12) College (1-4 or 5+) Oyrs stoa Be Maryland irst, Middle, Last) irst, Middle Maiden Surname) other's Name (F မ 100der oreen Informant's Name/Relationship (Type r or Rural Route Number, City or Town, State, Zip Code) 21228 KNOWN US 9 Catonsville lelores boode O Baltimore, 20a. Method of Disposition Date place)

2-2-2011

Covings Mills MD

Covings 20b. Place of Disposition (Name of Garrison Kores 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee 33 Balto. <u>91\r</u> MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ tailure. Acute respiratory disease or condition 5days Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): ig physician and as the burial-transit executed Due to (or as a consequence of): resulting in death) Last attending physician by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be exithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No jo Month Day 5 Other (specify) 1 ☐ Yes 2 L 9 ☐ Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Chronic renal insufficiency Completed 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 death? 1 🗌 Yes 2 1 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No မှ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending Accident 1 Yes 2 No Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 👱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practicinum to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as attack. only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Ceulia Yslin-Tamashiro RES-000 18, 2011 January 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) cecina yshii - Tamashico MO. of Bailimore Sinai Mospikul 31. Date filed (Month, Day, Year) 32. Registrar's Signature State IAN 21 parks Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 19 2011 3:34pm Grimes, Sr. January Dewitt Alton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Rockville Casey House If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Securi 2041 per Funeral 6. Sex 7. Age (In yrs. last birthday) 8 Date of Birth Month, Day. Days Hours Min 1 □**X**M 2 □ F 217-16-1924 87 Director MD Usual Residence of Decedent show 10h County aţ 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 3a or 28a-f sł t be notified a MD 1 Yes 2 XNo Howard Dayton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a Funeral USA 21036 4720 Linthicum Road items within 72 hours after death ı "natural", or item edical Examiner n 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 3 2 🗆 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify Specify White 3 Widowed 4 Divorced Completed Year or Dates Korea Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "I any injury or other traumatic event; the Med one. Elementary/Seconday (0-12) College (1-4 or 5+) Woodworking Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jessie Florence Gosnell Jesse E. Grimes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4720 Linthicum Road, Dayton, MD 21036 Mrs. Catherine G. Grimes (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State ¹X☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Linden Linthicum Cemi 1/24/2011 Clarksville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caused in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ COPD disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of Cause (Disease or linjury burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month 5 Other (specify) Year Pregnant at time of death Day 4 Pregnant
9 Unknown bed . the 9 Unknown þ be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Nunknown Completed Empyema should 24b. Were autopsy findings available prior to completion of cause of death? Pneumonia 24a Was an or Attending Physician: The law autopsy performed? Yes 2 XN has page 2 certificate 2 No 1 Yes 25. Was case referred to medical director. Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 🗶 No မြ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 🕅 Other (Specify) Hospice After this funeral 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural injury 5 Pending 24 hours after death. Funeral Director: A 1 Yes 2 No Accident Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 K Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2. To the only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) R143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Deborah Mitter, CRNP 6001 Muncaster Mill Rd., Rockville, MD 20855 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January MAXINE GIGIOUS 20, 2019 7:30A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1648 East Belvedere Avenue Baltimore None Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) g. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours Yrs 1070871918 Kentucky Director 400-12-1368 92 Usual Residence of Decedent 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f s notified Baltimore Maryland None 1XXYes 2 No 10e. Street and Number 10f. Zip Code r must be r 10g. Citizen of What Country? Funeral 1648 East Belvedere Avenue 21239 USA items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Jer Black, White, etc. 1 ☐ Yes 2 🗶 🎝 o ō Examir þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes XX No Specify "natural", Specify. Completed 3XXWidowed 4 ☐ Divorced White the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Il Hygiene. I **other tha**l Beautician 0wner permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygic Important: If item 27 is marked other any injury or other traumatic event, the other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Grant Weddington Nannie Conn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P₀A Elwood Doyle 1648 East Belevedere Avenue Baltimore, MD 21239 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State GreenMount Crematory 01/21/2011 |Baltimore, Maryland □ Donation 5 □ Other (Specify) nature of Funeral § 22. Name and Address of Factivitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Chysician/ disease or condition vance Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death
Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform After this certificate 2 X N 1 ☐ Yes 2 No Yes To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No 12 Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State within 24 hours a To the Funeral I Medical 1 Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 006317 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

JAN 2 1 2011

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32. Registrar's Signat

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Belair

altimore

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State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Rea. No. 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year 9:50 AM 2011 **Physician** HITE MARGARET /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, timore Examiner tome Birthplace (State or Foreign Country) nder 24 Hrs. 8. Date of Birth (Month, Day, (In yrs. last birthday) 6. Sex Age curity Number Days Hours Min **Funeral** 1 □ M 2 🔽 Yrs 216-14-5285 Usual Residence of Decedent Director 10d. Inside City Limits toc. Sity, Town or Location 10b. County filed within 72 hours after death with the Maryland 10a. State 1 ☐ Yes 2 ☐ No than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21133 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No 12. 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 New Married 2 Married Specify: Blac 1 ☐ Yes 2 ☑ No Specify: altimore, Maryland 21215-0036 ģ 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) cav Hygiene. Is marked other than rai Mildle Maiden Surname) 18. Mo s Name (First traumatic event, 17. Father's Name (First, Middle, Last) permit, Pages 1 and 2 should be file Department of Health and Mental Hi Important: If Item 27 Is marked oth any Injury or other traumatic event Be hompson ၉ or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City (Tpe. Print) 140. mi) 21207 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 2011 25. Jan. 4 ☐ Donation 5 ☐ Other (Specify) Greene Funeral Services 22. Name and Address of Facili 21. Signature of Funeral Service Licensee mD21/33 Dag an proximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed as the burial-tran and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760x attending physician 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery E FEMALE: use Day Year 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No for 1 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown 9 D Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 2 No 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 21 NK 1 ☐ Yes 26. Place of Death (Check only one) After this certific funeral director, I 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Inpatient 1∐ Yes 2 ☑ 🗖o Certification: To 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 5 Pending investigation 1 Natural s after dea.
ral Director: After 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined completely filled in by 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier CRNP ine Buch 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 Road 6811 campfield RNP Regina By 31. Date filed (Month, Day, Year) Birch 32. Registrar's Signature State parket JAN 2 1 2011 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 2011 Elizabeth 2:30 P Margaret Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Center If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1 🗆 M 2 🗶 F NewYork February 17 1927 83 Yrs. **Director** 214-24-6864 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director **Baltimore** Towson Mary land 1 Tes 2X No ě 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21286 U.S.A. 8604 Drumwood Road "natural", or items death Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 X Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary (Seconday (0-12) College (1-4 or 5+) the Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 7 is marked o marked o ဂ္ Brown Alfred G. Sparkes Ruth be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 8604 Drumwood Road Towson, Maryland 21286 Kathleen Hill / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Dulaney Valley Mem. Gdns. 1/22/2011 Timonium, Maryland 4 Donation 5 Other (Specify) Ruck Towson Funeral Home, Inc. 22. Name and Address of Facility 21. Signature of Funeral Service Lice 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ HPONICOBSTRUCTIVE PULMENARY Medical resulting in death) as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnan 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 - Fetal death in the past 12 month Month Day Year Pregnant at time of death detached the 9 Unknown þ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. s been signed to should be det 23e. Did tobacco use contribute to the cause of death? by BREASTCANCER Division of Vital Records, 1 ☐ Yes 2 ☐ No 3:☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has performed? Yes 2 No 2 No 1 Yes or Attending Physician: director, 25. Was case referred to prédical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 PNo ဂ္ 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (S funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred ☐ Natural 5 Pending n 24 hours after death.

le Funeral Director: Aft
bleted filled in by the fur 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) Daye filed (Month, Day, Year) State Registrar

⟨Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dav 642 M Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death ENCORE Ellicott City Howard Year If Under 24 Hrs. 8. Date of Birth **Funeral** 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days (Month, Day, Yea 7 1 □ M 2 Director Usual Residence of Decedent ms 23a or 28a-f shormust be notified at Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Howard Clarksville 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11755 Bragdon Wood 21029 USA "natural", or item edical Examiner n 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 (No Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates marked other than "natur matic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) elder care Mental Hygiene. business owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Dick Doane Ida Call 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S Health a Mr. Patrick Hinkson (spouse) 11755 Bragdon Wood, Clarksville, MD 21029 item 2 other 1 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Linden Linthicum Cem. 1-17-11 Clarksville, MD 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses Frederick types of spirit P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition nk nows , Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Examir 24 hours after death.
25 hours after death.
4 Funeral Director: After this certificate has been signed by the attending physician and leted filled in by the funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Pregnant at time of death Day 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 🗌 No 1 🗌 Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 2 🗆 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred Hospital or Attending 24 hours after death. Natural Accident 5 Pending 1 🗌 Yes 2 No Investigation Suicide Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 5 29b. Signature and title of certifier 30. Name and address of person who completed cause of Salaza

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Pepartment of Health and Mental Hygiene Registrar Reg. No. 1. Decedent's Name (First, Middle, Last)
John Hopkins 2. Date of Death Month 1/3/2011 Physician/ 10:05am Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis MD Anne Arundel Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1**X**XM 2 □ F 028-24-4987 Hours Months Min. (Month, Day, Year) 76 **Director** Yrs MA Usual Residence of Decedent 28a-f show 10a State with the Maryland notified at 10b Counts 10c. City, Town or Location 10d. Inside City Limits Director PA Lycoming Montoursville 1 ☐ Yes 2 1 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral 570 Sand Hill Road 17754 USA items within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. ŏ þ 1 Never Married 2 Married 1X Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify. White "natural" Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Executive 12 Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked of traumatic ever permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. Roy 2 Hopkins Conway Pearl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, /Daughter Anna P. Spangler 2599 Scranton Rd, Cleveland OH 44113 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Wildwood Cem. 1/7/11 Williamsport, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee VICTOR ^{22 Name and Address of Facility}
Charles L. Stevens Funeral Home, Inc.
1501 East Fort Avenue, Baltimore MD 21230 Vicos 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Delisis disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Pneumonia weins Sequentially list conditions, PROVED BY MEDICAL EXAMINER Examine in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the burial-transit and that initiated events CERTIFICATI resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical that the death certificate be 68760 as IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav Year Yes 2 No 9 Unknown 9 Unknown P.0. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Retroperitoneal hematoma Records, requires 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 X Yes 2 X No Hospital Other: 1 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred injury 1 🛮 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital o within 24 hours aff To the Funeral Di Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) D46052 01/04/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 Medical Parkery annapolis, Mus GERD BELLE MO

OHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

2011

Lawed

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Harmie Hurd Janua<u>ry</u> 10:55p Medical 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carroll 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 1 M 2 □ F Days Hours 83 March Day Year) Country) Director 413-52-0556 Yrs 1927 TN Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at Id be filed within 72 hours after death with the Maryland Mental Hygiene. 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Carroll Marriottsville 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7443 Marriottsville Rd. #2 21104 USA 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 🏌 No Yes If Yes, Give Year or Dates 1 Yes 2 XNo Specify "natural", Specify: White 3 Divorced Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Seconday (0-12) College (1-4 or 5+) driller quarry is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Isom Hurd permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Molly Willis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rena Hurd (spouse) 7443 Marriottsville Rd. #2, Marriottsville, MD 21104 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Springfield Cemetery 1-18-11 Sykesville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Haight Funeral Home & Chapel Paige Haight Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Heart Atheroscherote disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year signed by the at d be detached fo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been signification can be considered to the category. Completed 1 ☐ Yes → No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 🗌 No 1 🗆 Yes Yes 2 No 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) ျ 1 ☐ Yes 2 ☐ No Other 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 5 Pending iniury Investigation Could not be 2 No Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 within 24 hours after death. To the Funeral Director: After this Certificate: filled in by Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗀 only one) 29b. Signature and title d f certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 01

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number DO061755 Poole Hemal Westminster, MD 21157 eanna 31. Date filed (Month, Day, Year)
JAN 2 1 2011 32. Registrar's Signature

State Registrar

			Please Type or Prin Amend #22, per Fh g911 1, State of Ma	t in Black Ir /21/11 TT ryland / Depa	idelible Ink. Ens u artment of Health a	i re All Copies nd Mental Hvoi	Are Legible. ene
		•	State Registrar		tificate of Death	Re	g. No. CUIIUO
	Physicia		1. Decedent's Name (First, Middle, Last) TRACY HIPLEY			2. Date of Death	Day Year
1	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of		4c. County of Death
- '	/		5. Social Security Number 6. Sex 7, Age	(In yrs. last birthday)	BALDWOR		Birthplace (State or Foreign
	Funeral Director		. D 108 -	10 Yrs.	Months Days Hours	Min. 8 (Month, Day)	Year) Country) MT)
	nd how at	'n	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation		10d. Inside City Limits
	Maryla 28a-f s ptified	Director	MD Baltimore	Baltimo	ore		1 ☐ Yes 2 X ☐ No
	th the		10e. Street and Number		10f. Zip Code	10	0g. Citizen of What Country?
	ems 2	Funeral	405 S. Northpoint Road 11. Marital Status 12. Was Decedent Ev		21224 Vas Decedent of Hispanic Origi		14, Race - American Indian,
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	<u>ج</u>	1 ☐ Never Married 2 🖾 Married	0	Yes, specify Cuban, Mexican, Yes 2 No Specify:	Puerto Rican, etc.)	Black, White, etc.
8	hours a natura ical Ex	letec	3 ☐ Widowed 4 ☐ Divorced Year or Dates. 15. Decedent's Education		lent's Usual Occupation		Specify: White 6b. Kind of Business Industry
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/lan	d be fill dental irked o	2	Howard J. Baisley			ela Souder	,
Maryland 21215-0036	should and N and N is ma		19a. Informant's Name/Relationship (Type, Print)	1	g Address (Street and Number		
e, 1	and 2 Health tem 2:		Steve Hipley - Husband 20a. Method of Disposition	20b. Place of Dispos	sition (Name of	nt Rd., Ra	Itimore, MD 21224 Oc. Location - City or Town, State
Ē	Page 1 nent of ant: If i		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		atory or other place) Crematory		len Burnie, MD
Baltimore,	ermit. Jepartn mporta ny inju		21. Signature of Funeral Service Licensee	22	. Name and Address of Facility	Bradley-A	shton Funeral Home
	00 = 60		23a. Part 1. Enter the disease, or complications that caused the	PA	, 2134 WOLL	low Spring	Road, 21222
	Physician/		shock, or heart failure. List only one cause on each line.		ta iwrz	,	Interval Between Onset and Death
-	Medical Examiner		resulting in death) Due to (or as a continuous and a cont	consequence of):	111(00)00		
		Jer	Sequentially list conditions, if any, leading to immediate b. Due to (or as a condition)				Unknown
	uted Id ansit	Examiner	Cause (Disease or iinjury that initiated events		TERY DISER	HE	Unknown
	ciar ciar ouris	<u>ē</u>	resulting in death) Last Due to (or as a c	onsequence of):	,		
200	aath certificate be ex attending physician for use as the burial	l edic	d				
Box 68760	h certif tending r use a	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of 1 ☐ Live Birth 2	pregnancy Fetal death 3	Ectopic pregnancy		23d. Date of delivery
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o Li	rding I ith. : After e funer	cate	27. Manuer of Death 1 Natural 5 Pending 2 Accident Investigation	(ear) injury	28c. Injury at work? M 1 ☐ Yes 2 ☐ N	28d. Describe how	injury occurred
Division of Vital Records,	or Atter fter dea irector in by the	Certificate:	3 Suicide 6 Could not be	- At home, farm, stre Specify)	et, factory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
۵	spital o		29a. Certifier 1 Certifying Physician: To the best of my	/ knowledge, death o	ccured at the time, date and pla	ace, and due to the cause	e(s) and manner as stated.
	To the Hospital or Attending Physician: The law requires that the death certificate twithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the total the completed filled in by the funeral director, page 2 should be detached for use as the total than the funeral director.	Medical	(Check 2 ☐ Medical Examiner: On the basis of examiners on the basis of examiners on the basis of examiners on the basis of examiners on the basis of examiners. To the basis of examiners on the basis of examiners on the basis of examiners.	mination and/or investi	gation, in my opinion, death occu	urred at the time, date and	place, and due to the cause(s) and manner stated.
	With Con		29b. Signature and title of certifier	man M	29c. License number	7/	d. Date signed (Month, Day, Year) ANUASY (3, 2011
5			30. Name and address of person who completed cause of deat	th (Item 23a) (Type, Pi	int) Isadore		
			Johns Hopkins at Bay View 31. Date filed (Month, Day Year) 32. Registrar's		astern Avenue	Baltin	ore, Maryland 2122
	Stat Registra	_	JAN 2 1 2011 Augus	A. Ma	Ke		
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			Amend #1, per MI	e Type or Pri	nt in E	Black Ir	ndelik artme	ole Inl	k. Ensure	All Copie	s Are	Legibl	e.	
		•	For State Registrar	Otato or ivi	ai yiai i			te of L			Reg. No	/ 11	1 0110	9
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	Medical Examiner 4a. Facility Name (if not institution, give street and number						4b. City	, Town, or	r Location of Death		4c.	County of D		
	- <u>-</u>		NWHWEXT 5. Social Security Number 16	. Sex 7. Aq	ne (In vrs. la	st birthday)		anoler 1 Year	If Under 24 Hrs.	8. Date of Bi		3a (+1	Birthplace (State or Fore	eian
	Funeral Director		219-38-9683	1 X M 2 □ F	69	Yrs.	Months		Hours Min.	(Month, D	ay, Year)	41	Country) M.D	
	and show at	'n	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo							10d. Inside City Lim	iits
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	with the 23a or ist be r		10e. Street and Number 9613 Orpin Ro	nd Ant 20	Δ		10t. Z	ip Code 21	133		10g. Cit	tizen of What		
	items	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S	13.	Was Dece		ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)	-	14. Race - A	merican Indian,	
036	e filed within 72 hours after death with the Maryland ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ed by	1 XNever Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 Yes 2 X If Yes, Give Year or Dates.	No				Specify:		- 1	Specify: B		
21215-0036	72 hour "natu edical	Completed	15. Decedent' (Specify only highest				kind of w	ork done d	during most of wor	king	16b. K	ind of Busine	ss Industry	
212	within representations with the minimum of the mini		Elementary/Seconday (0-12) 12th grade	College (1-4 or 8	5+)			se retired) Ce C	fficer		Bal	timor	e City	
pue	e filed ntal Hy ed oth event	To Be	17. Father's Name (First, Middle, Las						18. Mother's Nan			Sumame)		
Maryland	of Health and Mental F of Health and Mental F fitem 27 is marked o r other traumatic eve	•	Nathaniel Har 19a. Informant's Name/Relationship			19b. Mailir	ng Addres	ss (Street	and Number or Ru			Town, State,	Zip Code) 2113	33
			Denise Harris	on-Daught					Road Ar				stown Mo	
Baltimore,	age 1 and 2 ent of Healt nt: If item 2 y or other 1		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp.	Removal from State	. C6	lace of Dispo emetery, crer utus	matory or	other place		Date L / 1 1	1	utus,	or Town, State Md	
3altii	permit. Page 1 a Department of I Important: If ite any injury or ot		21. Sgnature of uneral Service Lie		habo	(O.A. M.E.	2. Name a	ind Addre	ss of Facility West					
	<u> </u>		23a. Part 1. Enter the disease, or co	omplications that cause	d the death	4	300	Waba	sh Ave			e, Mo	Approximate	
shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition					Interval Between Onset and Death									
	Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):								
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequ	ence of):								
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00		I = I		d										-
68760	ertifical ding ph se as th	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								23d. Date of	delivery	
Вох	Attending Physician: The law requires that the death certificate be stream. The actor. After this certificate has been signed by the attending physici by the funeral director, page 2 should be detached for use as the bu	Physician/Medica	in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown			Cother (Month	Day Year	
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ds, I	v requires the special	ted by								1 🗆	Yes 2	□ No 3 □	Probably 4 Unkno	own
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Vit	Physician; this certific al director,	မ	examiner? 1 Yes 2 No			R/Outpatie			4 L Nursing F	leme -5 🗌 Res			pecify)	
o uc	nding F ath. :: After t	icate	27. Manner of Death 1 Natural 5 Pending 2 Accident Investiga	28a. Date of inju (Month, Da	iry iy, Year)	28b. Time of injury	M	28c. Injur work 1 🗔		28d. Describe	how injur	y occurred		
The state of the s						Rural Route Number,								
	pspital hours a ineral C	Medical (29a. Certifier 1 Certifying F	Physician: To the best of	f my knowle	edge, death	occured a	at the time	e, date and place, a	and due to the d	ause(s) ar	nd manner as	stated.	atatad
	thin 24 thin 24 the Fu	Me	(Check 2 ☐ Medical Ex- only one) 3 ☐ Certifying N 29b. Signature and title of certifier	aminer: On the basis of e lurse Practioner: To the	best of my	knowledge,	death occ	urred at the	e time, date and pla	at the time, date ace, and due to f	he cause(s	s) and manner	r as stated. onth, Day, Year)	,iaicu.
	5 × 5		I Turke	47				1	62650			16-1		
	,		30. Name and address of person wi	no completed cause of c	1		Print)		ail Stown	1 := 5				
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr		ure voc	cl 1	and	all Hollin	PID	211	53		
	Registra		JAN 2	1 2011 12	ered .	, A	lons	Kel						

amend #20h Per FH C912/3/01/11 Jh 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 18 2011 10:11a Hilliard 01 Wilbert /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince Georges Health Center Hyattsville Cheverly ler 1 Year | If Under 24 Hrs. If Under 1 Birthplace (State or Foreign Country) 6. Sex 1 Year Days 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**√** M 2□ F Hours Min Yrs. Director 76 213-32-4698 10 07 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or Iteme 23a or 28a-f ehow the Medical Examinar must be notified at 1 Yes 2 □ No Directo MD Baltimore NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21207 U.S.A. 6401 Laurel Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) EEO Specialist Federal Government 12th grade 2yrs Ith and Mental Hygir 27 te marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Wilbert Holloway Bernice Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6401 Laurel Drive, Baltimore, Md 21207 Barbara Hilliard-Wife Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 2/03/2011 Pages jo 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) = 5 Department of Important: If eny Injury or once. Garrison Forest Vet 1/27/2011 Owings Mills, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a Anderioscle ste Candiovasov kin Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit Exami Due to (or as a consequence of): physicien a Box 68760, Physician/Medical use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. ete has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Encohalistan III 100 -- 26. Nice of Dyath (Check only one) 1 ☐ Yes 2 ☐ No and or Attending Physician: After this certific funeral director. 25. Was case referred to medical Hospital: 1 Inpatient examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending efter death. Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours e To the Funeral C completely filled Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated, Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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DHMH 17 Rev 1/2001

State Registrar 32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** PM 2011 Sharon A. Harris /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Franklin Square Hospita ROSECIALE If Under 1 Year If Under 24 Hrs. Baltimore Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 1 M 2 F Min. Months Days Hours 215-60-4104 55 September 30,1955 **Director** Maryland Usual Residence of Decedent 10c. City. Town or Location 10a. State 10h County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examiner must be redifficed at once. 1 ☐ Yes 2 No Director Md. Balto. Nottingham 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3802 Wean Drive 21236 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Office Worker Insurance 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian (unknown) ဥ Casimar Goralski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Harris Spouse 3802 Wean Drive Nottingham, Md. 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Moreland 1-24-2011 Parkville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Schimunek Funeral Home 9705 Belair Road Nottingham, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Under ing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed physician and s the burial-transit neumonio Due to (or as a consequence of): Box 68760, Physician/Medical attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a d be detached for Ö 9 Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an The law has page certificate 1 ☐Yes 2 ☐ No 1 □ Yes 2'No Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number TANUARY, 15, 2011

Registrar DHMH 17 Rev 1/2001

State

Harris

John Kattarathil 9000 Franklin Square Drive Baltimore, MD 21237 (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

2 1 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep			lental Hygi	ene	
	_		Registrar 1. Decedent's Name (First, Middle, Last)	ertificate of Death			g. No.	W. 1 1 1 5
п	Physicia	n/				Date of Death Month	Day Year	3. Time of Death
	Medic Examin		Ruth M. Hall 4a. Facility Name (if not institution, give street and number)	Tab City Town and applica	n of Dooth	January		9:40 P M
	Examin	er	Manor Care	4b. City, Town, or Location Potomac	II OI Death		4c. County of Death	2017
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under	er 24 Hrs.	8. Date of Birth	Montgome g. Birthp	ace (State or Foreign
	Director		578-16-0278 1 □ M 2 🖾 F 91 Yrs.	Months Days Hours	Min.	sep 18,		ngton, DC
	F MO		Usual Residence of Decedent					
	rylan -f sh ied a	cto	10a. State 10b. County 10c. City, Town or L				10	d. Inside City Limits
	e Ma r 28a notifi	Director	Maryland Montgomery 10e. Street and Number	Potomac				1 Yes 2 No
	ith th	ra I		10f. Zip Code		10	g. Citizen of What Count	•
	ath w	Funeral	10714 Potomac Tennis Lane 11. Marital Status 12. Was Decedent Ever in U.S. 13.	20854 Was Decedent of Hispanic O	rigin? (Cno	oif. Vac or Na	United Sta	
(0	or ite	by F	1 Never Married 2 Married Types 2 No	If Yes, specify Cuban, Mexica	an, Puerto I	Rican, etc.)	14. Race - America Black, White, e	
8	ral", Exar	pa	3 ☒ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 🛣No Specify	fy:		Specify: Whi	te
21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation		1	6b. Kind of Business Ind	ustry
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Ž	should be file n and Mental 7 is marked of raumatic eve		Chaunzy Kurtz 19a. Informant's Name/Relationship (Type, Print) 19b. Mail		Emma			
Σa	2 sho Ith an 27 is trau			ing Address (Street and Numb N. Sycamore F			ity or Town, State, Zip Ci dona, Arizor	<i>'</i>
ē,	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition 20b. Place of Disp				Oc. Location - City or Tov	
Ω	Page 1 ment of ant: If it ury or o		1 ☐ Burial 2X Cremation 3 ☐ Removal from State cemetery, cre	matory or other place) rney Crematory			•	
Baltimore,	# P T = 1						Woodbine, M	
Ö	permi Depar Impor any ir once.		Juanta Ruhmas M00957 Be	2.Name and Address of Facil Ding Home Crem Everly L. Heck	nátior krotte	n Service e, P.A. (P.O. Box 7 Clarksville,	/84 MD 21029
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9289	law requires that the death certificate itse been signed by the attending phys 2 should be detached for use as the	Med	IF FEMALE:					
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Division of Vital Records,	has by	Completed				24a. Was an autopsy	prior to com	y findings available pletion of cause of
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2	tal or rs aft al Dir ed in		building, etc. (Specify)		- 4	City or Town, S	State)	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2:	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or invest	occured at the time, date and	d place, and	due to the cause	(s) and manner as stated	e(s) and manner stated
	the l	ž	only one) 3 ☐ Certifying Nurse Practioner: To the best of my knowledge, 29b. Signature and title of certifier	death occurred at the time, date	te and place	, and due to the ca	use(s) and manner as stat	ed.
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		ŀ	20. Name and address of paragraphs and address of all the control of the control	D00545	000	J	anuary 19,	2011
			30. Name and address of person who completed cause of death (Item 23a) (Type, Sunitha Bhogavilli M.D. 9801 Coore		34. A	17 0'3	C	m 20000
	Stat	e	Sunitha Bhogavilli, M.D. 9801 Georg 31. Date filed (Month, Day, Year) 1 201 32. Bigistrar's Signature	ra Avenue, Su	TTE I	-I/ Silv	er spring,	VID 20902
	Registra	r	JAN & I ZUII Januar Jo. 19	W. C.				

DHMH 17 Rev 7/2009

11-00507

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Ronald Stanley Ha	1	- For State	tate of Maryla		artment of <i>rtificate of</i>		d Mental F		eg. No. 20	i odda
Physician	1	Registrar 1. Decedent's Name (First, Midd Ronald Stanle						2. Date of Dea Month	ath Day Year	3. Time of Death 1341 hrs
Medical Examine		4a. Facility Name (if not institution		ımber)		4b. City, Town, or	Location of Deat	January 1	8, 2011 4c. County of De	
	ľ		Atlantic General Hospital			Berlin			Worcester	
Funeral Director		5. Social Security Number 220-82-9069	6. Sex	7. Age (In yrs. 49	last birthday) Yrs	Months Day		n.	rth(MM/DD/YYYY) 9. Fo 1, 1961	Birthplace (State or reign Country)
	-	Usual Residence of Decedent 10a. State 10b. County		Inc. City	, Town or Locat	ion				10d. Inside City Limits
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5-0036 ed within 72 hour lygiene. inther than "natu the Medical Exar	3	17. Father's Name (First, Middle			J			e (First, Middle,	Maiden Surname)	
21215-0036 Montal Hygiene. marked other than "natural", or items 23a nr 28a-f shore event, the Medical Examiner must be notified at once. To Be Commission by Eumeral Director		Stanley Daw			T.2				th Fruchte	
and 2 should leath and Mer tem 27 is man traumatic ev	2	19a. Informant's Name/Relations Stephen Haas		r		,			nber, City or Town, Ste, MD 2122	_
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a nr 28a-f she injury or other transmatic event, the Medical Examiner must be notified at once. To Re Commissed by Firnaral Director	- 1	20a. Method of Disposition			Place of Dispos	ition (Name of ce	metery,	Date	20c. Location - City	or Town, State
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Baltimore, permit. Pages 1 ar Department of Hec Important: If ite		21. Signature of Furteral Service	The V	7/2 m					Funeral Ho Arbutus,	•
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). Box 6 the death cer by the attendiached for use.	3		4 Pregn	ant at time of de	eath 5 Ot	ner (Specify)				
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Division of Vital Records, P.O. tal or Attending Physician: The law requires that the ra after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach artification: To Be Completed by P										robably 4 🗹 Unknown
Records, The law requires ficate has been sig, page 2 should be								24a, Was autop		autopsy findings available to completion of cause of 2
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Division or ppital or Attending tours after death. neral Director: After filled in by the function:		dete	ld not be rmined (Specify)	e of Injury - At h	ome, farm, stree	et, factory, office b	ouilding, etc.	or Town, S		Rural Route Number, City
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To the Hos within 24 h To the Fut completely		one) 2 Medical Exa	and manner s		and/or investigat			at the time, date	and place, and due to	
△		29b. Signature and title of certific		ONIN		29c, Licens O.C.			January 19, 20	
		30. Name and address of person	who completed caus	se of death (Item	n 23a)				, , , , ,	
181		•	sistant Medical	•		imore Street,	Baltimore, M	1D 21223		
State Registra		31. Date filed White, Pay Year)		gistrar's Signal	are face	1				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mabe1 В. Jones 19:05 PM tanuary 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice at Northwest Randallstown Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 1 🗆 M 2 👿 F Country) 82 Director Vrs 215-22-1572 928 Usual Residence of Deceden or 28a-f shov 10a. State 10b. County death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Carrol1 Sykesville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 6202 West Hemlock Drive 21784 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if item 27 is marked any injury or care. þ 1 Never Married 2 X Married 1 Yes 2 No Specify White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Wheeler Leroy Lillian Viola Wasky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Theodore H. Jones (Spouse) 6202 West Hemlock Drive, Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 KBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. 1/25/2011 Owings Mills, MD 21. Signature of Funeral Service License 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA Hau 400764 PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Pnysician/ 5 disease or condition Medical resulting in death) Due to or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Day Vear 2 No ed by the sidetached f 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed 2 No 1 \square Yes npleted filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: Hopky Vall မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1-Gritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one 29b. Signature and title of certifier January 17,2011

Registrar
DHMH 17 Rev 7/2009

State

6934 Rustion Blud 21061

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

BRUM

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Physician/ Month Year 2357pM Alisa Jones Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimor FRANKLIN Square Roseda HOSPITa Birthplace (State or Foreign Country) Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** (Month, Day, 9-22-Months Hours Min 1 □ M 2XX MD 219-92-7417 Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State M D 10b. County 10c. City, Town, or Location
Parkville with the Maryland Director Balto 1 Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 21234 print. Page 1 and 2 should be filed within 72 hours after death with repartment of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural" --- any injury or other traumatic exercise. 7608 Daniels Avenue USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11 Marital Status Armed Forces Black, White, etc. ð 1 XNever Married 2 Married Yes 2 X No Black 1 Yes 2X No Specify: If Yes, Give Specify. Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry na (Specify only highest grade completed) (Give kind of work done during most of working na life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ٥ Valerie Cornish Frederick C. Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) LaChanna Jones-Sister 7608 Daniels Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-21-2011 Balto, MD Greenmount East F/H March Signature of Funeral Sovice Licensee 22. Name and Address of Facility Avenue Balto, MD 21202 1101 Ε. North 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ rdia Pulseless disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner TioLo uncertain Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Embolism attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury usepect that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Unknown signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 0625 1 🗌 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an in 24 hours after death.

The Funeral Director: After this certificate has apleted filled in by the funeral director, page 2 s autopsy performed? death? 1 🗌 Yes 2 🗎 No Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 I DOA 2 No မြ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Unit of the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1-10-11 RES0000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Jarks

. Registrar's Signature

9000 FRANKlin Square DR Ballo Md

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 2011 3:36 P M Barbara Ann Joines Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Cecil Elkton Union Hospital Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min Dec. 29, 1962 1 □ M 2 🔀 F Country Maryland Director 218-86-5498 48 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d, Inside City Limits Director 1 ☐ Yes 2 🏝 No Maryland Cecil Elkton 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 21921 USA 100 Laurel Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 X Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: Completed 3 Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) <u>Disab</u>led 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Jeanette King Aubrey Edward Joines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aubrey E. Joines / Father 6121 Davis Road, Woodbine, MD 21797 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Whitehead-Joines Cem. 1-22-11 <u>Sparta. North Carolina</u> 21. Signer, le of Funeral Service 22 Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abing Abingdon. MD 21009 23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a conse ueno of): Examiner ENUT Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Vear Pregnant at time of death Yes 2 X No signed by the a 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an sate has by page 2 s autopsy r this certificate h performed' 1 🗌 Yes 2 🗌 No Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA After this funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 🗆 Pending 1 ☐ Yes 2 ☐ No I Director: A 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Direct completed filled in by Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner To the best of my knowledge, death commod at the time, date and place, and due to the coince(s) and many as state 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) D005950 30. Name and address of person nplated cause of death (Item 23a) (Type, Print) ho co

Registrar

State

Z 107 istrar's Signature

San Sal Santon

BRINGE ST. EIKTON, N.D 21921

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician P^{M} 2011 5:00 16. Januarv Robert Leroy Johnson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner n/a Baltimore 4513 Green Rose Road Date of Birth (Month, Day, Y 8/4/49 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Year) Hours Days Months 12√M 2□ F Director 216-52-3469 61 Maryland Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time 27 is marked other than "naturali", or items 23a or 28a-f show any injury or other traumatic event, transcaling the most formation or other traumatic event, transcaling the most feature must be notified as 1 X Yes 2 No Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4513 Green Rose Road 21213 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ⊠ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify. þ 3. Widowed 4 □ Divorced **Black** Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Coke Oven Worker Beth Steel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edith Virginia Deneal ဂ Calvin Johnson Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn V. Weems / Sister 4616 Marble Hall Road Baltimore, MD, 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 1/21/2011 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Loudon Park Funeral Home 21229 3620 Wilkens Ave. Baltimore, Maryland 23a. Part 1. Enter the disease, or coruc l'ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he art failure. List one one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) ---/Medical Due to (or as a c -equence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Understand Cause (Disease or injury Due to (or as a construence of) Examine To the Hospital or Attending Physiclan: The law requires that the death certificate be executed physician and s the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 5 Other (specify) Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No as S certificate 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a, Certifier 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

South

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jan. $2\mathbf{I}^{y}$ 201°1 10:14 A M Margaret Pinholster Koppleman Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4118 Villa Nova Road Baltimore Gwynn Oak Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Georgia 1 □ M 2 😾 F (Month, Day, Year) 0V. 16. 1925 Months Hours Min. 226-22-5700 **Director** 85 Nov. Usual Residence of Decedent is than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Directo Baltimore 1 Yes 2 X No Gwynn Oak 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21207 4118 Villa Nova Road United States within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give X
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Home Maker Own Home Copperation of Health and Mental Hys. Supportant: If item 27 is marked other any injury or other traumair. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daniel Pinholster Lois Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Mullineaux/Daughter 2307 Bachman Valley Rd., Manchester, MD 21102 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 01/22/2011 Baltimore, Maryland 21. Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Rd., Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of): disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examir that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death ned by the a 1 L Yes 2 19 Unknown 9 | Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 2 No 1 Yes 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 2 🔀 No 1 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending work?
1 Yes 2 No 24 hours after death. Funeral Director; A Accident Suicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c License number 029085 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ID 1133 丁 - \subset 31. Date filed (Month, Day, Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Richard Wallace Kimberly January 3:37 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Regional Hospita Laurel aure Prince George's If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1**▼** M 2 □ F Country) Michigan Days Hours Nov. 23, 1928 Director 369-28-7161 Yrs. Usual Residence of Decedent show 10a. State 10b. County at 10c. City. Town or Location 10d. Inside City Limits Director event, the Medical Examiner must be notified 28a-f MD Prince George's Laurel 1 Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g, Citizen of What Country? by Funeral 23a 14200 Laurel Park Dr., #108A 20707 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, was Decedent Ever in U.S. Armed Forces? 1½ Yes 2 □ No If Yes, Give Year or Dates. Unknown Black, White, etc. ō 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify. "natural", Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Antique Dealer Sales is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Det mit. Page 1 and 2 should be 1 Det artment of Health and Menta. Aun; ortant: If tem 27 is marked any injury or other traumatic ew once. ည UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura McFeeley / Granddaughter 8426 Snowden Oaks Pl., Laurel, MD 20708 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 01/19/2011 Baltimore, Maryland 21. Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 day S Immediate Cause (Final Physician/ Congestive Heart disease or condition Medical resulting in death) Examiner Due to (or as a consequence of) Cardiovascular Disease teriosclerotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Diabetes Mellitus ending physician and use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last death certificate be executed Due to (or as a consequence of Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year 9 Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No ည 1 Yes Other: 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at After 28d. Describe how injury occurred Natural 5 Pending injury work? 24 hours after death. Funeral Director: Af 2 🗌 No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the P within 2. 29b. Signature and title of certifier January 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bowie Rd., Suite 208 Sadia Registrar

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20 II Kadesch Month Gwendolyn 921 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Washington Adventist Hospital Takoma Park 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF Days Hours **Director** 225-50-9378 08/27/1939 28a-f shov 10a. State 10b. County death with the Maryland , or items 23a or 28a-f sho iminer must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring MD Montgomery 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20904 127A 531 Randolph Road, Apt. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, an "natural", or iter Medical Examiner Black, White, etc. should be filed within 72 hours after on and Mental Hygiene. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☒ Xo If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. White Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) or other traumatic event, the <u>dministrative Assistant</u> Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
Gayle Payne ္ရ Carl Edward Duehring 19a. Informant's Name/Relationship (Type, Print) o. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4289 Ringwood Road, Nokesville, VA 20181 permit. Page 1 and 2 st.
Department of Health ar
Important: If item 27 is Jeffrey D. Kadesch 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State rinal Journey Crem. 1/24/2011 Woodbine, MD 4 Donation 5 Other (Specify) 21. Signature of Fuperal Service Licensee Dorota Marshall 22. Name and Address of Facility Services Maryland PO Box 1 Cremation Ser 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Obstructive Lung Stane Chronic Medical resulting in death) Examiner Hospita Days acquired Preumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician and I for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month. Day Year g Unknown 9 Unknown Division of Vital Records, P.O. Part II. **Other significant co**nd**itions** co*n*tributing to death but *n*ot resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Aortic Valve Disease Status Post Replacement Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performe Yes 2 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: ဂ္ 1 Nonpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending Natural work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) D61067 January Physician 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

KHANDAGLE

31. Date filed (Month, Day, Year)

32. Registrar's Signature

12520 Prosperity Drive #320 Silver Spring Maryland 20904

Patient Known as Robert Katzoff

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		١.	For State	State of Ma	arylan		artment of <i>tificate of</i>			vlental Hy	Ŭ	201	1	01121
			Registrar 1. Decedent's Name (First, Middle, Las	t)		Cei	incate of	Deau	1	2. Date of De	Reg. No	0.		3. Time of Death
	Physicia Medic		ROBERT D.	KATZOFF						Januar		ay Ye		0453AM
	Examin		4a. Facility Name (if not institution, give	street and number)			4b. City, Town	, or Location	on of Death		7	c. County of D		
امر	/	L	Sinai Hospita	al of Ba		nore_	Balt	imo		city			N/A	
	Funeral Director		5. Social Security Number 6. Sec. 216–28–6169	7. Age	(In yrs. la	ast birthday) Yrs.	If Under 1 Yea Months Day		der 24 Hrs. s Min.	8. Date of Bir (Month, Da 04/02/	1192	2	Birthpla Country	ace (State or Foreign V) MD
	within 72 hours after death with the Maryland jiene. sr than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at.	tor	Usual Residence of Decedent		10c. City	γ, Town or Lo	cation LTIMORE						10	d. Inside City Limits
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	hea hea		JUDY ROSENTHAL / 20a. Method of Disposition	DAUGHTER	20b. P	lace of Dispo	ARCOLA sition (Name of			ILVER S		NG MD Location - City		0902 n, State
Ë	Page nent or ant: If ant: If ury or		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		ARIC	TYGKON A	natory or other p	M •	01/2	0/2011	BA	LTIMORI	Ε, Μ	ID
Baltimore,	permit. Page 1 s Department of H Important: If ite any injury or ot		21. Signature of Funeral Service Licens		1	22	. Name and Add	lress of Fa						
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8	certifi inding use as	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of			Teteste seine					23d. Date of	f deliver	у
X POX	death	Completed by Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at			Other (specify)					Month		Day Year
у. Э.	at the	Phy	9 Unknown Part II. Other significant conditions of		ıt not resi	ulting in the u	inderlying cause	given in P	art I.	23e Did i	tobacco	use contribut	a to the	cause of death?
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0	ding P h. After t funera	Certificate:	27. Manner of Death 1 Natural 5 Pending	28a. Date of injur (Month, Day,	Year)	28b. Time of injury	W	jury at ork? □ Yes 2	. □ No	28d. Describe	how inju	iry occurred		
SIO	Attendr deat	rtific	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Inju					I INO	28f. Location (Street ar	nd Number or	Rural F	Route Number,
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	lospit 4 hour uners	Medical	29a. Certifier 1 Certifying Phys (Check 2 Medical Exami	sician: To the best of r	ny knowl	edge, death o	occured at the til	ne, date a	nd place, ar	nd due to the ca	ause(s) a and plac	and manner as	s stated the caus	se(s) and manner stated
	the h	Me	only one) 3 Certifying Nurs 29b. Signature and title of certifier				death occurred at		date and plac		he cause	(s) and manne	r as stat	ed.
-	≒ ≥ 5 8		A A	Ac	MI	>		S - C			250. Di	ate signed (M	orian, De	9. 20U
			30. Name and address of person who c	ompleted cause of de	ath (Item	23a) (Type, F		1/	,		Vul	igary	ı	1) 0(
			Justin M. S	haw, M	D	5	Thai	Ho	spita	al o	f	Balti	mo	re
	Stat Registra		31. Date filed (Month, Day Year) 2 1	2011 32. Registra	r's Signat	ure A.	pares		,					

Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12:50 Pm 2011 John Wesley Kinnier January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1311 Glendale Rd. Baltimore Baltimore . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** . 1<u>937</u> Days Min. 1**X**M 2 □ F Months Hours JuIV 16 Nebraska 508-38-0521 73 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho dical Examiner must be notified at Director 1 🗆 Yes 2 💢 No Maryland | Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21239 1311 Glendale Rd. United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Year or Dates. 1959-85 Completed 3 Divorced 4 Divorced white If Hygiene.

other than "naturater, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government n and Mental Hygien naval officer/engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked cany injury or other traumatic evenore. John Alexander Kinnier Alice Marie Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John W. Kinnier II/son Catonsville. 21228 Edmondson Ave. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XX Burial 2 Cremation 3 Removal from State Arlington National Cem ^{June} 3,2011 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, 16500 York Rd. Baltimore, MD 2 21. Signature of Funeral Service License But 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Due to (or as a cons quence of): DISEASE ARTERY Medical resulting in death) Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 4 Pregnant Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ER UPIDEMIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this the funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury Natural 5 Pending within 24 hours after death.

To the Funeral Director: After completed filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier

20

State Registrar

DHMH 17 Rev 7/2009

1501

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CONNOIS

OBEST

31. Date filed (Month, Day, Year)

JAN 2 1 2011

SOUTH CLINTON ST

18, 2011

BALTIMURE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month conge 10) and was 201 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Days 3 Hours Min 1 🗆 M 2 🗓 F 218-89-6685 Maryland 2011 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c City Town or Location 1 Yes 2 No Maryland Harford Abingdon 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number 233 Lodge Cliff Court 21009 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes : 1 ☐ Yes 2 🔀 No Specify 3 Divorced 4 Divorced Year or Dates: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 0 Never Worked 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Aaron Keleman Mary Elizabeth Gunning 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 233 Lodge Cliff Ct., Abingdon, MD 21009 Joseph A. Keleman / Father Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Darlington Cemetery 1-22-11 Darlington, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Funeral 50 W. Broadway, Bel Air, MD ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death 23a. Part 1. Enter the one and thock, or heart failure. art 1. Enter the disease, or complicate Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.) Due to for as a nonsequence of: that initiated events resulting in death) Last Due to (or as a consequence of): pregnancy 23d Date of delivery Fetal death 3 Ectopic pregnancy Month Day Year 5 Other (specify) e of death 23e. Did tobacco use contribute to the cause of death? not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 1 Yes 2 No 26. Place of Death (Check only one)

Physician /Medical **Examiner**

physiciar

Physician

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

"natural",

and Mental Hygiene.

permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 is
any injury or other trau

the Medical

filed within 72 hours after

Baltimore, Maryland 21215-0036

Director

Funeral

2

Completed

Be

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/Medical

the funeral

requires that the death certificate be executed

Box 68760,

P.O.

Division of Vital Records,

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To the Hospital or within 24 hours a To the Funeral D

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	Physician/Medical	I 2
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3 Suicide

29a. Certifier (check only

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4 - Homicide

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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown
Part II. Other significant condition	ns contributing to death but r
25. Was case referred to medical	
examiner? 1 ☐ Yes 2 🗶 No	Hospital: 15 Inpatient
27. Manner of Death 1 Natural 5 Pending investigation	

6 Could not be

determined

Hospital:	2 FR/Outpatient	3 🗆 DOA

28b. Time of

Other: 4 \sum Nursing Home 28c. Injury at Work? Injury 1 Yes

. Place of injury - At hon building, etc. (Specify) At home, farm, street, factory, office

Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

600 North Wolfe St, Baltimore, MD, 21287

5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

29b. Signature and title of

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

and address of person who completed cause of death (Item 23a) (Type, Print)

Gilmore 31. Date filed (Month, Day,

32. Regis rar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month . Decedent's Name (First, Middle, Last) 3. Time of Death 39 Pacility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death mol Date of Birth (Month, Day, Birthplace (State or Foreign Country) . Age in vrs. last birthday Sex 12AM 2□ F Days Year) Hours Min Yrs Maryland 55 2-3-1955 213-68-1266 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6031 Arizona Avenue 21206 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∏Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Disabled None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rita Ann Wielepski F. Kistler, Sr 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6031 Arizona Avenue Balto. Md. 21206 Susan M. Kistler Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 1-14-2011

Physician /Medical Examiner

Physician /Medical

Examiner

10a. State

Md.

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Funeral

Director

28a-f show

ral", or items 23a or 28a-f shore

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7 Is marked of traumatic ever

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Department of Health ar
Important: If Item 27 Is
any Injury or other trau
once.

Director

Funeral

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Completed

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with the Maryland

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Examine physician a s the burial-1 Physician/Medical attending pl for use as t for cate has been signed by the page 2 should be detached ģ Completed funeral director, Be Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed

After this certificate

nours after death.

neral Director: Af

filled in by the fur

within 24 hours a To the Funeral D

Medical

Division of Vital Records, P.O. Box 68760,

23a. Part 1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

23b. Was decedent pregnant

in the past 12 months? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical

3 Suicide

29a. Certifier

4 Homicide

IF FEMALE:

4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fur eral Service Licens

	e cause on ach line.
a a	Due to (or as a co
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23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

9 Unknown

Bayview

death.

nsequence of)

3 Ectopic pregnancy

5 Other (specify)

9705 Belair Road

Do not enter the mode of dying, such as cardiac or respiratory arrest,

23d. Date of delivery Month

Balto.Md.

Nottingham, Md.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably

autopsy 2 🗆 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

24a, Was an

28d. Describe how injury occurred

22. Name and Address of Facility Schimunek Funeral Home

24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 ☐ Yes

Day

Year

Approximate nterval Between Ogset and Death

examiner?	0	Hospital:	Inpatient	2 🗆 🗉	ER/Ou
27. Manner of Peath 1 Natural 2 Accident	5 ☐ Pending investigation	28a.	Date of Injury (Month, Day, Ye		28b. T

utpatient 3 DOA Time of njury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2122

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

6 Could not be determined

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940 Eastern eson MD Bottomore, MD Ave

State Registrar 31. Date filed (Month, Day, 2 1 201

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 55 a M awingki Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** <u>Joseph Richey</u> Hospice **Baltimore** 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1 **⊠**M 2 □ F Months Days Hours *3*75773916 Maryland 94 Director 213-07**-**5621 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 X Yes 2 ☐ No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21239 USA 2015 Crestview Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: and Mental Hygiene.
is marked other than "natural",
aumatic event, the Medical Exa Specify: Completed 3 Wildowed 4 Divorced White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bethlehem Steel Electrical Supervisor Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Kaminski, Sr. Helen Cieshynska 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 807 Light Street <u>Richard E. Kaminski</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🗷 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/22/2011 | Baltimore, Maryland oudon Park Cemetery ! 22. Name and Address of Facility Loudon Park Funeral Home Signature of Funeral Service Licensee Baltimore, Maryland Wilkens Ave. 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on wone cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): as been signed by the attending physician and 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown g Unknown Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsv performed? Yes 2 No page death? Hospital or Attending Physician: The 1 🗌 Yes 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) **Division of Vital** Hospital 2. No Other: မ 1 🗌 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No M Accident Investigation 24 hours after death 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

2

8:55F

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 19ay 2011 Tear Deborah L. Lawler 8:44 Ρм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2 - X F (Month, Day, Year **Director** 60 Maryland 217-56-8935 951 Ian Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at Director 10b. County 10a. State 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits MD. Carroll Eldersburg 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 6602 Slacks Rd. 21784 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify: White Specify 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within Department of Heath and Mental Hygiene. Important: If item 27 is marked other than any injury or other transmit. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Assistant Principal Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Betty Catherine Cusick William Anthony Lane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas J. Lawler, III/ Husband Slacks Rd. Eldersburg. MD.6602 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Hilltop Service Co. 1-25-11 Towson, MD. ^{22. Name and Address of Facility}
Ruck Towson Funeral Home,
1050 York Rd. Towson, MD. Signature of Funeral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ Corgnant cell Medical resulting in death) ue to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence or Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year signed by the at d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has page 2 s performed this certificate 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence & Other (Specify No PLC) ဂ္ 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After Natural N 5 Pending iniury Accident work?
1 ☐ Yes 2 ☐ No Investigation within 24 hours after death

To the Funeral Director: ,
completed filled in by the ; 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and tit of certifier icense number 29d. Date signed (Month, Day, Year) 2011 58307 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 wolved 12 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 6:54 AM LANGHAN PATRICIC 7.4NUAR 201 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** BAUTIMORE HARISOR CITY HOSP ITA If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours (Month, Day, Year Jan 4, 1954 Country) 214-76-1771 1 🗓 💥 M 2 🗆 F 54 MD Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 Yes XXX No Anne Arundel Linthicum 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21090 507 Darlene Ave 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 XXNo Maryland 21215-0036 1 ☐ Yes XX No Specify Specify: White 3 Widowed 4 XXDivorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Heating & Air Conditioning HVAC Technician Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ٥ Mary Hintze William J. Lanahan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 507 Darlene Ave, Linthicum, MD 21090 Tina Comma Sister Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2XX Cremation 3 Removal from State Jan 25, 2011 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 22. Name and Address of Facility The of Funeral Service Fink Funeral Home, P.A. 426 Crain Hwy S. Glen Burnie M01148 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Enter the disease 23a, Part shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician, CORONARY ARTERY DISTASS ATHEROSC LEROTIC Medical resulting in death) Due to (or as a consequence of Examiner YEARS Sequentially list conditions. Examiner it any, leading to immediate cause. Enter Underlying Due to for as a consequence of, Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy Month Year in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death been signed by the a should be detached f 9 Unknown q Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available 24a. Was an autopsy performed prior to completion of cause of death? s certificate has the lirector, page 2 s 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 00 1 🗌 Yes 1 Inpatient 2 FR/Outpatient 3 IDOA ၉ funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? s after death. Il Director: Afi ed in by the fur 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours after
To the Funeral Directory Medical 1 Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 70358 MEDICAL DOCTOR JANUARY 20, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL 3001 SOUTH HANOUER STRE HARBOR 32. Registrar's Signature State Supposed. Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) January Physician/ 19^{ay} 201[°]1° 8:58A M Joyce Lucas Linda Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Anne Arundel <u> Annapolis</u> Medical Center <u>Anne Arundel</u> 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year | If Under 7. Age (In yrs. last birthday) **Funeral** Mar 10, Year 951 Months Days 1 □ M 2**X** F Hours Min. Maryland 59 Director Yrs 216-54-6205 Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10c. City, Town or Location permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at 10a, State Director 1 X Yes 2 No Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral United States 21230 124 West Ostend Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian. 11 Marital Status Black, White, etc. ð 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 XNo Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Program Planning & College (1-4 or 5+) Elementary/Seconday (0-12) Financial Control Manager Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည McKenzie Jo Stanley Dyson John 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 4505 Owens Valley Drive West River, MD 20778 Richard Dyson/brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Woodbine, Maryland Final Journey Crematory 1/22/2011 4 Donation 5 Other (Specify) 21. Sign re of Funeral Service License Sing Home Cremation Service P.O. Box 784 M00957Beverly L. Heckrotte, P.A. Clarksville, Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Immediate Cause (Final disease or condition resulting in death) Physician/ Medical or as a consequence of) Examiner Sequentially list conditions, Examine Due to or as a consequence of) cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy Month in the past 12 months?
1 Yes 2 No Day signed by the atte Pregnant at time of death 5 Other (specify) g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 XNo Yes 2 No 1 Yes certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 Ninpatient 2 ER/Outpatient 3 DOA 1 \square Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ည After this nin 24 hours after death.

the Funeral Director; After this

mpleted filled in by the funeral of Manner of Dea Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: Natural Accident work' 5 Pending 1 ☐ Yes 2 ☐ No Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 4 Homicide determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, in my opinion.

Certifying Nyse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2. only on signed (Ma nth. Dav. Year 29d. Date 29b. Signature Name and address of pe 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 4:15 P M Lesniewski Josephine Jan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Co. Rossville Manor Care Rossville Nursing Home Year If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 8. Date of Birth Funeral Month, Day, Year, July 22, 1 Mary Land 1 - M 2 X Months Days Hours **Director** 219-30-6900 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location Director 1 ☐ Yes 2X No Rossville Baltimore 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? Funeral 21237 United States 6600 Ridge Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Yes 2 No Specify: White Completed 35€ Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 Years Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sophia Knotek Joseph Dominiak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21219 7519 North Pt. Road Edgemere, Maryland Sandra M. Walsh (Granddaughter) 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 1/18/2011 Oak Lawn Cemetery Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
Dundalk Marvland 21222 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final THEROSCLEROTIC Physician/ CARDIOVASCULAR DISEACE Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No page 2 should be detached for Month Day Yea 5 Other (specify) ☐ Unknown ned by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4. Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

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Medical

27. Manner of Death

1 Natural

4 Homicide

29a. Certifie (Che

Signature

Accident Suicide

State Registrar

npleted cause of death (Item 23a) (Type, Print) 194ETETUPAL 31. Date filed (Month, Day,

5 Pending

and title of certifier

Investigation 6 Could not be

determined

9106

28a. Date of injury (Month, Day, Year)

MITTEL ADELPHIA

Certifying Nurse Fractioner To the best of my knowledge, death ordered at the time, date and place; and due to the ex-

28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D0660560

#208

28f. Location (Street and Number or Rural Route Number, City or Town, State)

numarish and m

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 16 Day Year Physician/ 11:02 AM EIESTE 2011 LOTZ JAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Good Samaritan Hospital Baltimore City N/A 8. Date of Birth (Month, Day, Year Jan 25 1 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🔀 F **Director** <u>Maryland</u> 219-26-5376 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Dunda1k Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ŏ Funeral items 23a Apt. 200 7801 Peninsula Hwy. United States 21222 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 XWidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Steel Industry 12 Years Secretary permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, ti Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Jennie Luco Edward Aus Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 00 First Street Apt. 239 Rockville, 19a. Informant's Name/Relationship (Type, Print) 20851 100 First Street Mrs. Frances Yates (Sister) 20a. Method of Disposition 20b. Place of Disposition (Name of emetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal 1/20/2011 Baltimore, Maryland 4 Domation 5 Other (Specify) Lawn Cemetery 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222 Juneral 21. Signature of 23a. Part 1. Enter the disease, or complications that cursed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ BACTEremia disease or condition resulting in death) Medical Due to (r as a consequence of): **Examiner** FIBRILATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami GRAVIS To the Hospital or Attending Physician: The law requires that the death certificate be executed MIASTENIA that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 by Certificate: To Be Completed

within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu

FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	24a. Was an autopsy performed? Composition 1 1 2 2 2 2 2 2 2 2				
Part II. Other significant condition Movbid Ob					
		autopsy prior to completion of cause of death?			
5. Was case referred to medical examiner? 1 ☐ Yes 2 🌠 No	Hospital:				
	(Month, Day, Year) injury work? ion M 1 ☐ Yes 2 ☐ No	. Describe how injury occurred			
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin					

🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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HOSPITAL 5901 LOCA RAVEN BLU Baltimore MD 21239

29c. License numbe ₽ES

29d. Date signed (Month, Day, Year)

JAN 16, 2011

State Registrar

DHMH 17 Rev 7/2009

Medical

29a. Certifier

only one)

29b. Signature and title of certifier

ZYY

31. Date filed (Month,

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHAYUK GOOD SAMAVITAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Hanuar /Medical 4a. Facility Name (If not institution, give street and number) ounty of Death **Examiner** Date of Birth (Month, Day, Ye Birthplace (State or Foreign Country) **Funeral** . Age (In yrs. last birthday 1 M 2 M Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show 1 ☐ Yes 2 ☑ No Completed by Funeral Director 10e. Street and Number 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 2 any lipury or other traumatic event, the Michael Esser. 12. Was Decedent Even U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 □Yes 2 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced 190 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) nsinea 17. Father's Name (First, Middle, Last) ner's Name (First, Middle, Maiden Surname, Be ဂ Informant's Name/Relationship (Type. Print 19b. Mailing Address 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Funeral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one caus, on each line. Approximate Interval Between Onset and Death such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** ear Due to (or as a consequence of /Medical Examiner Sequentially list conditions, any, teaching to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Day to (or as a consequence of): law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy To the Hospital or Attending Physician: The performe 2 🗆 No 1 ☐ Yes 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only on-) Other: 4 Sydrsing Home 5 Residence 6 Other (Specify) 1 Yes 2 N Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Deal 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Copper fid 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 21

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2:12 PM 2011 Physician/ JANUARY MILLER ELLIOTT HARVEY Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** BALTIMORE #508 2903 FALLSTAFF ROAD, Birthplace (State or Foreign Country) 8. Date of Birth If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Days 11/15/1930 **Funeral** 1 X M 2 □ F 80 214-26-2188 Director Usual Residence of Decedent 10d. Inside City Limits 3a or 28a-f show t be notified at 10c. City, Town or Location 10b. County 10a. State Director 1 X Yes 2 No BALTIMORE N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 21209 2903 FALLSTAFF ROAD, #508 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items : any injury or other traumatic event, the Medical Examiner mu 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Black, White, etc. Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 X Married ð 1 Yes 2 No Specify: Specify. Baltimore, Maryland 21215-0036 WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) DIRECTOR OF PUBLIC RELATIONS MARTIN MARIETTA 5+ 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) ပ REBECCA MILLER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2903 FALLSTAFF ROAD, #508, BALTIMORE, MD EILEEN MILLER/WIFE 20b. Place of Disposition (Name of Date 20a. Method of Disposition cemetery, crematory or other place)
MIKRO KODESH BETH
ISRAEL CEMETERY 1XXBurial 2 Cremation 3 Removal from State BALTIMORE, MD 01/19/2011 4 Donation 5 Other (Specify) SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Esuphagen News Physician/ disease or condition resulting in death) Due to (or as a consequence of) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Year Day in the past 12 months?
1 ☐ Yes 2 🔀 No Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical completed filled in by the funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 🛣 No ျှ 28b. Time of 28c. Injury at 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: work? 1 \sum Yes 2 \sum No 1 X Natural 5 Pending Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after deal To the Funeral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 6 Could not be 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 29b. Signature and title of certifie gross 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4105 31. Date filed (Month, Da State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Examin		4a. Facility Name (if not institution,	give street and number)			r Location of Dea	th	4c. Coun	ty of Death	
			Manor Care N	ursing Home		Balti		- T · · · ·		1	
	Funeral		,	6. Sex 7. Age (In)	yrs. last birthday, Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	n. (Month, D	ay, Year)	9. Birth	place (State or Foreign etry)
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ةِ و	or i	Ş	1 Never Married 2 🗆 Marr	Armed Forces? 1 ☐ Yes 2 No If Yes, Give		If Yes, specify Cuba 1 ☐ Yes 2 🗓 No		no nican, etc.)		ack, White,	
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Dalumo	artme ortar injur	1	21. Signature of Funeral Service L	A -	On-S:			21/2011	Darci	more	, Mu
	pornier age rate and popular popular popular popular popular if item 27 is marked any injury or other traumatic evonce.		Dorone.	tensee Manba	ا س	P. Name and Addre March F/ 4300 Wab	H West ash Ave	e. Balt	imore.	Md	21215
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, de serve de	Medical		disease y condition resulting death)	a Due to (or as a con							
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	certif	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		Oth	lace of Death (Ch				
> H	this ral di	은	27. Mann of Death	1 ☐ Inpatient 28a. Date of injury	2 ER/Outpati 28b. Time	ent 3 ⊔ DOA	4 Nursing	Home 5 Res	idence 6 L Ot how injury occu		2
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SIO	ctor:	Ę	3 Suicide 6 Could in 4 Homicide determ	not be 28e. Place of Injury				28f. Location	Street and Num	ber or Rura	I Route Number,
DIVISION OF	Dire din b		4 - Homicide determine	building, etc. (Sp	pecify)			City or To	wn, State)		
DIVISION OF VICE HECOIDS, F.O. BOX 08/00 To the Hospital or Attending Physician: The law requires that the cleath certificate be executed.	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendit completed filled in by the funeral director, page 2 should be detached for use	edical		Physician: To the best of my k							
i	in 24 he Fi iplete	Mec		xaminer: On the basis of examin Nurse Practioner: To the best							
Ē	To to		29b. Signature and title of certifier	200	MA	29c. Licens		le	29d. Date sign		Day, Year)
			pusar		1.00	ho	06931	7	1 1	9 111	
			30. Name and address of person v		(Item 23a) (Type	Print)	ملممل	Rd P	Marilo	M	21234
			31. Date filed (Month, Day, Year)	32. Registrar's S	,	- I MA	~~~	, - 10			
	Sta Registra		JAN 2 1 2011	h h	ha a a						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#11perFH,G911,1725/2011,WS State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Physician/ Month Henry Arthur Mullen 5000 M IANU Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Doctor's Community Hospital Lanham If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 XM 2 - F Months 99 Yrs. **Director** 364-12-3940 1912 Massachusetts Jan Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 Yes 27 No MD Prince George's Mitchellville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20721 United States 3800 Lottsford Vista Rd. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?
1 ☐ Yes 2 ☐XNo Black, White, etc Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 □ Divorced If Yes, Give Specify: White Year or Dates injury or other traumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 F Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n any injury or other traumatic event, the Mediaore. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing 4 <u>Metalurgical</u> Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mullen Helen I. Anderson James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Anne Rydlewicz / Daughter 5433 31st St. NW, Washington D.C. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory, 1/21/2011 Beltsville, MD 21. Signature of Fungrar Service Lightsee M00382 22. Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Inset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) neumon Medical Due to (or as a consequence of) Examiner em Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause or linjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy performed 1 Yes 2 No After this certificate Yes 25. Was case referred to medical examiner?

1 \(\text{Yes} \quad 2 \text{No} \text{No} \) funeral director, æ 26. Place of Death (Check only one) Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\) Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ၉ Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending within 24 hours area
To the Funeral Director: Af 1 Yes 2 No 2 Accider Investigation Accident 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number D528

State Registrar 31. Date filed (Month, Day, Year)

JAN 2 1 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State of	Marylan		artment of I		nd Mei	,	<i>p</i> **	0.1.1	1, g g ,,
	_	-	Registrar 1. Decedent's Name	e (First, Middle, L	ast)		061	tineate or i	Death	2	Date of Dea	Reg. No.	3 1 1	3. Time of Death
	Physicia		Joa	ın	Mil1	ard					Month Januar	Dav	2011	12:15 A ^M
	Medic Examin		4a. Facility Name (if	not institution, gi				4b. City, Town, c	or Location of [Januar	1	unty of Death	12:13 A
ne or	LAdiiii		Casey	House					ville			- 1	Montgo	merv
	Funeral		5. Social Security N			. Age (In yrs. la	st birthday)	If Under 1 Year	If Under 24		Date of Birtl	1	g, Birth	place (State or Foreign
	Director		363-07-9	1490	1 □ M 2 X F	102	Yrs.	Months Days	Hours	Min. J.	(Month, Day an . 1() • 190	9 New	York
	D 00 4	ا۔ا	Usual Residence of 10a, State	Decedent 10b. County		10c City	, Town or Loc	ation					1.	Od. Inside City Limits
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	or 28; notii	P	10e. Street and Nun	nber			wası	nington	D.C.			10a Citizer	of What Cou	
	with ti	Funeral Director	2725 29	th St. N	W #315			200	08			5	d Stat	•
	eath v	اجّا	11. Marital Status		12. Was Deced			Vas Decedent of H	lispanic Origin	? (Specify	Yes or No-		Race - Americ	
Maryland 21215-0036	s after d al", or i Examin	þ	1 ☐ Never Marr	ried 2 Married	Armed Force 1 Yes 2 If Yes, Give Year or Date	2 XNo		Yes, specify Cub		Риепо ніса	an, etc.)		Black, White, ecify: W	_{etc.} hite
Ŏ	hour natur lical	Completed	/0	15. Decedent's	Education			ent's Usual Occup				16b. Kind	of Business In	dustry
215	in 72 e. han "	티	Elementary/Seco	onday (0-12)	College (1-4	l or 5+)	(Give k	ind of work done NOT use retired,	during most of)	t working	1	_		
7	y with ygien her tl			2			Mana	ager, H	at Shor)		Re	tail	
pu	e filec ttal H ed ot	To Be	17. Father's Name (,	irst, Middle, I	Maiden Surr		
3	uld be I Men narke		Andre		Banas	zak			Mar	·-			Bete	
Nai	shoot h and 7 is n traun	Ш	19a. Informant's Na	-	_(Type, Print) Conservat		1	g Address (Street				*		Code)
ē, L	Healt tem 2	Ш	20a. Method of Disp		onservat	20b. Pl	ace of Dispos	71 42nd A	1	Date			98125 ion - City or To	own. State
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.		4 Donation	5 Cother (Spec		State Che	emetery, crem esapeal	etory or other place Cremat	tory 1	/21/2	2011	Ве	ltsvil	
Ba	permit Depar Impor any in		21. Signature of Fur	neral Service Lice	nsge Munan	M003	82 22	Rame and Addre Rapp Fund 933 Gist	eral an Ave.,	nd Cre	ematio er Spr	n Ser	vices MD 20	0910
			23a. Part 1. Enter t shock, or hear	he disease, or con rt failure. List only	mplications that ca one cause on each	used the death h line.	. Do not ente	r the mode of dyir	ng, such as car	rdiac or res	spiratory arre	est,		Approximate Interval Between
9 1	Physician/		Immediate Cause (disease or conditio		D.	ementia	1							Onset and Death
	Medical Examiner		resulting in death)	•	Due to (or	r as a consequ	ence of):							
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876	ificating phase as th	Mec	IF FEMALE:											
Box 687	eath certifical attending ph I for use as th	an/	23b. Was decedent in the past 12 r		23c. If yes, outco	ome of pregnar irth 2 🗌 Fetal	ncy death 3 🗆	Ectopic pregnan	су			23d	. Date of delive	,
Bo	deat the at ned fo	Physician/Me	1 Yes 2X	XNo	4 🗌 Pregna 9 🗌 Unkno	ant at time of de	eath 5	Other (specify) _					Month	Day Year
P.O.	es that the dea signed by the a I be detached f		Part II. Other signif		contributing to dea	ath but not resu	ulting in the ur	nderlying cause gi	ven in Part I.	Т	23e Did to	hacco use o	contribute to th	ne cause of death?
σ.	res th signe d be c	d b	Pneum				Ü	, , ,						pably 4 X Unknown
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~	ding Physician: The le h. After this certificate ha funeral director, page		Dysph 25. Was case referre					•••		(0)	1 Yes		1 🗆 Yes	2 🗆 No
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<u></u>	Physical distribution	욘	27. Manner of Death			patient 2 🗆 E	=R/Outpatient 28b. Time of	28c. Injur	4 ∟ Nursi		5 L Reside Describe ho		-	Hospice IPU
ū	th. : Afte	cat	1 X Natural 2 ☐ Accident	5 Pending Investigation	28a. Date of (Month)	, Day, Year)	injury	work	k? Yes 2 □ No		. Describe ne	W Injury Co.	ouriou	
Division of Vital Records,	Atter	Certificate:	3 Suicide 4 Homicide	6 Could not	be 28e, Place o			et, factory, office		_			ımber or Rural	Route Number,
Ω̈́	tal or rs afte al Dir				building	g, etc. (Specify)					City or Town	n, State)		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2	Medical Exar	ysician: To the bes niner: On the basis rse Practioner: To	of examination	and/or investi	gation, In my opini	on, death occur	rred at the	time, date ar	d place, and	d due to the car	use(s) and manner stated.
	To th Within To th comp		29b. Signature and t		7 -A			29c. Licens					gned (Month, i	
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			30. Name and addre											
4_			Debrah M					Mill Rd	, Rock	ville	e, MD	2085	3	
2	Stat Registra	te ar	31. Date filed (Month	2011	32. Re	strar's Signati								
4 DHM	/IH 17 Rev 7/20			7-0	7	**								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 18 2011 1:10 P M John W. Mangun January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Holy Cross Hospital Montgomery Silver Spring 8. Date of Birth (Month, Day, Year Sep 2, 19 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Country) (unk) Months Hours 519-16-7191 Director 89 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important If item 27 is marked of outber than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8505 Springvale Road 20910 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? 1X Yes 2 □ No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) 12 College (1-4 or 5+) Office Worker Financial Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (unk) (unk) ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Pennington/Executor/Friend 919 Country Club Dr Harpers Ferry, WV 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 **Cremation 3 ** Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 1/21/2011 Woodbine, Maryland re of Funeral Service Licer Going Home Cremation Service P.O. Box 784 M00957 Beverly L. Heckrotte, P.A. Clarksville, M 23a. Part it Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate attending physician and for use as the burial-transit Cause (Disease or iinjury Pneumonia that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hypoxemia Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) Pregnant at time of death 2 No 9 Unknown 9 I Inknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes Mellitus 1 Yes 2 No 3 Probably 4 Nonknown 24b. Were autopsy findings available Severe Aortic Stenosis 24a. Was an prior to completion of cause of death? Jas autops performed? Yes 2 No this certificate 1 Yes 2 No the Hospital or Attending Physician; Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: ဂ္ 1 ☐ Yes 2 🔀 No 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of <u>ë</u> 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) work? 1 X Natural 5 Pending injury Accident 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number hm an an D66372 January 18, 2011

State Registrar

N DHMH 17 Rev 7/2009

Silver Spring, Maryland 20910

1500 Forest Glen Road

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Majid Rahmanian, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Anni Masevicius January 4:00 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 231 4th Avenue Landsdowne Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/23/25 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs, last birthday) 1 M 2 K Months Days Hours Min. 217-38-0878 85 Germany Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 → No MD Landsdowne Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 231 4th 21227 Avenue USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 🔄 No Specify: Specify: 3 Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Molter Anna Weigand 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor Brown Daughter 231 4th Avenue Landsdowne, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 1/24/2011 4 ☐ Donation 5 ☐ Other (Specify) | Baltimore. Marvland Loudon Park Cemeterv 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Dense 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): > By GGRS ANTESIO SCIENCHIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hupertension, Tupe & Diabetes, Chronic Abril Tehnillation 1 ☐ Yes 2 2 lo 3 ☐ Probably

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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ges 1 and 2 should be filed within 72 hours after death with the Maryla nt of Health and Mental Hygiene.

If item 27 is marked other than "natural", or items 23a or 28a-f shov or other traumatic event, the Marylast Examiner must be notified at

2 should be fill and Mental H

Pages

permit. Page Department of Important: If any injury or

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed and burialphysician the attending p for use as t ed by the signed to cate has by page 2 s To the Hospital or Attending Physician:

Box 68760,

Division of Vital Records, P.O.

certificate After th funeral within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

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Completec	111111111111111111111111111111111111111	sevire, Osteoar.	thithis,	Reinent	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No					
0	25. Was case referred to medical		26. Place of Death (Check only one)								
To B	examiner? 1 ☐ Yes 2 🗖 No	Hospital: 1 ☐ Inpatient 2 ☐] ER/Outpatient 3□	DOA Other: 4 \(\sum \) Nursing	Home 5 Residence 6	G ☐ Other (Specify)					
ation:	27. Manner of Death 1	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury	y occurred					
Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, fact	ory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,					
dical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	nysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, death occurr ation and/or investigat	ed at the time, date and pla ion, in my opinion, death oc	ce, and due to the cause(s) curred at the time, date and	and manner as stated. place, and due to the cause(s)					

29c. License number 127541 29d. Date signed (Month, Day, Year)

Svite 41, Baltimory, MD-21227

January 19,2011

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Cillou

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAEETHA RAJA WD, 4367 HOMMS FRMY

Laya MI)

4067 HOMMS Ferry Rd,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Mallory Minnie 2011 01 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Dundalk Baltimore Road Trappe 8. Date of Birth (Month, Dey, Yeer)

April 22,1920 Virginia If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) 5. Social Security Number Deys 1 □ M 2 € F Yrs 90 227-09-7499 Usuel Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☒ No Dunda1k MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 111 Trappe Road 21222 United States 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Yes 2X No If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: 34 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) Attendant Public Schools 8 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Morris Clarence Collier 19e. Informent's Name/Relationship (Type, Print) (Daughter) (9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dundalk, Maryland 6 Midway Ave. Mrs. Barbara L. Mariano 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XBurial 2 ☐ Cremetion 3 ☐ Removal from State Holly Hill Mem. Gdns. 1/24/2011 Middle River, MD 4 Donation 5 □ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licensee 7922 Wise Ave. Dundalk, Maryland 21222 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. probable Alzheimer type Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 M 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Maturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide

To the Hospital or Attanding Physician: The law requiras that the death certificate be assocuted within 24 hours aftar death.

To the Funeral Director: After this certificate has been signed by the attanding physician end completely filled in by the funeral director, page 2 should be detected for use as the burial-transit Division of Vital Records, P.O. Box 68760,

by Physician/Medical Examiner

Be Completed

Medicai Certification: To

Physician

/Medical

Examiner

Funeral

Director

r items 23e or 28a-f ehow wher must be notified at

Funeral Director

þ

Completed

Be

Peges 1 and 2 should be filed within 72 hours after death with the Marylend nent of Health end Mental Hygiena. Int: If Item 27 is marked other than "natural", or Items 23e or 28a-f ehow

Department of Health e important: if item 27 is any injury or other tra pnce.

Physician

/Medical Examiner

Baltimore, Maryland 21215-0020

25. Was case referred to medical examiner? 27. Manner of Deeth 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the ceuse(s) and manner as steted.

2 Medicaf Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier

29b. Signature and title of certifier

29c. License number

antoni

State Registrar 31. Date filed (Month, Dey, Year)

JAN 2

Michele

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $\underline{1}_3^{\mathsf{Day}}$ Physician/ Month George John McIntire, Jr. 2011 Year Jan. 3:20 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Co. Charlotte Hall Charlotte Hall Veterans Home Social Security Number If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 7. Age (In yrs, last birthday) 8. Date of Birth **Funeral** 1 🛣 M 2 🗆 F Months Days Hours (Month, Day, May 21. Min. 1945 **Director** Maryland 65 5-46-6681 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Examiner must be notified at 10d. Inside City Limits Director 28a-f 1 ☐ Yes 2 No Westfield PA Tioga Co. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 150 North Street Apt. A-202 United States 16590 items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. "natural", or \$ 1 🕅 Never Married 2 🗆 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Completed 3 Divorced Year or Dates. Vietnam White the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Organist Church 12 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George John McIntire, Sr. Eleanor Catherine Schoene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David T. McIntire (Brother) 150 North St. Apt. A-202 Westfield, PA 16590 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 1/25/2011 Owings Mills, MD 4 Donation 5 Other (Specify) Garrison Forest V.A. Cem . Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ZHEIMER'S Physician/ DISEASE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate Examine Due to for as a consequence of cause. Enter Underlying Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? 2 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ျှ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check з 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0067788 MD 14 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAO KODALI Hall Rd Charlotte Hall, MD 201022 19449 Charlette. 31. Date filed (Month, Day, Year) 37. Registrar's Signature State JAN 21 Registrar

DHMH 17 Rev 7/2009

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			State Registrar			rtificate of C			g. No 0	01140		
	Physicia Medi	cal		1c Coy		T		2. Date of Death Month January	Day Year 17th 20 11	3. Time of Death 02:30A M		
	Examir	ner	4a. Facility Name (if not institution, give s Good Samaritan	Hospita	1		Location of Death		4c. County of Deat	h		
	Funeral Director		5. Social Security Number 214–48–5673									
	Maryland 28a-f show otified at	Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County N/A	1	0c. City, Town or Lo Bal	timore				10d. Inside City Limits 1 XYes 2 □ No		
	/ith the 23a or st be n	ral D	10e. Street and Number 5309 Hamlet Avenue			10f. Zip Code 2121 4	1	10	 Gitizen of What Coulomb 	untry?		
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ance.			I2. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates.	,	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Whi	e, etc.		
Baltimore, Maryland 21215-0036	vithin 72 hour giene. er than "natu the Medical	Completed by	15. Decedent's Edu (Specify only highest grad Elementary/Seconday (0-12)	cation	(Give	dent's Usual Occupa kind of work done do OO NOT use retired) rity Officer	uring most of work	ing	6b. Kind of Business Dacus Secur	,		
yland	id be filed w Mental Hyg arked othe atic event,	To Be	17. Father's Name (First, Middle, Last) Frederick L. McCoy				Elizabet 	e (First, Middle, Ma Crowley				
Mar	d 2 shou alth and 127 is n er traum		19a. Informant's Name/Relationship <i>(Typ</i> Patricia M. Chavez/ [19b. Maili 62 Gr	ng Address (Street a eenknoll Bot	nd Number or Rura Jlevard Ha	al Route Number, C Inover, Mary	ity or Town, State, Zip 11an d 21076	Code)		
imore,	Page 1 an ment of He tant: If iten lury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State		osition (Name of matory or other place Prvice Corp.	1/19/		oc. Location - City or DWSON Maryla			
Balt	Depart Import any in		21. Signature of Funeral Service License	Ilon	2	2. Name and Addres copard J. Ri 305 Hartord	sof Facility JCK Tinc Road Balt	imore Marv	land 21214	· · · · · · · · · · · · · · · · · · ·		
	nysician Medical Examiner		23a. Part 1. Enter the disease, or complishock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	Due to (or as a co	onsequence of):	er the mode of dying rrhosis alcaho		or respiratory arrest	,	Approximate Interval Between Onset and Death UNKNOWN		
	ate be executed hysician and the burial-transit	dical Examiner	Cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to lor as a consequence of: C. Due to (or as a consequence of): d.									
Division of Vital Records, P.O. Box 6876	In the Hospital or Attending Physician: The law requires that the death certificate within 24 bours affect death. Within 24 bours affect death. Completed filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Sc. If yes, outcome of 1 Live Birth 2 L 4 Pregnant at tin 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of del Month	ivery Day Year		
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Hecor	The law rec ate has bee page 2 sho	Completed						24a. Was an autopsy performe	prior to c	opsy findings available completion of cause of		
Ţ.	sician: The la certificate hi irector, page	Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:		0.1	ce of Death (Check					
010	ng Phys fter this ineral di	ate: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of injury (Month, Day, Y	2 ER/Outpatie 28b. Time of injury		at	me 5 Residence 28d. Describe how	ce 6 Other (Speci injury occurred	fy)		
JIVISION	ne Hospital or Attending Physin 24 hours after death. Per Funeral Director: After this pleted filled in by the funeral di	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of City or Town, State)							al Route Number,		
-	lo the Hospital of within 24 hours af To the Funeral Discompleted filled in	Medical	only one) 3 L Certifying Nurse	er: On the basis of exan	nination and/or inves	tigation, in my opinior death occurred at the	n, death occurred at time, date and plac	the time, date and i	place, and due to the c	ause(s) and manner stated.		
	viti To 1		29b. Signature and title of certifier Evasu	lekonen	M.D	29c. License			I. Date signed (Month			
•	7		30. Name and address of person who con				Mek			, 2011		
	/		31. Date filed (Month. Dav. Year)				MD 2	1239				
	Stat Registra	e ar	31. Date filed (Month, Day, Year)	A LAND STATES	Signature Lave							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JANUARY 2011 Mbengue Mohamed 1:15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BALTIMORE SAINT JOSEPH MEDICAL CENTER TOWSON 5. Social Security Number If Under 1 Year I If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Funeral Days (Month, Day, Year) 16 201 1**X** M 2 □ F N/A **Director** Usual Residence of Decedent or 28a-f shov 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Baltimore MD 1 🛚 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21212 901 Woodson Road #D 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🗓 No If Yes, Give ģ 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: Black Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 75 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) N/A N/A N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ndidadll Mbengue 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 901 Woodson Road #D, Baltimore, Md 21212 Papa Mbaye 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 🗋 Donation 5 🗆 Other (Specify) cemetery, crematory or other place) 1/19/201 Woodlawn, Md Memorial Park 21. Signature of Funeral Service Licensee Marchad room of Welly t 2 4300 Wabash Ave, Baltimore, 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ANOXIA disease or condition resulting in death) Medical Due to (or as a consequence of): . Examiner PREVIABLE Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Examiner Due to (or as a consequence of) Cause (Disease or linjury The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Year signed by the 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à PRETERM LABOR 1 \square Yes 2 \square No 3 \square Probably 4 \square Unknown Completed PREMATURE RUPTURE OF MEMBRANE 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page performed? Yes 2 No death? 1 Yes 2 No Yes the Hospital or Attending Physician: 25. Was case referred to medica 8 26. Place of Death (Check only one) 1 ☐ Yes 2 🛛 No Other: ᅆ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at After t 28d. Describe how injury occurred 1 XNatural 5 Pending injury n 24 hours area he Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

MELISSA

31. Date filed (Month)

Κ.

Day, Year)

2

7601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.,

Registrar's Signatur

EMERSON,

70665

OSLER DRIVE,

01/16/2011

TOWSON, MARYLAND 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ TANUAR NEWNIAN 2210 M HARRY FRANCIS Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death RAVEN LOCH BALTIMONE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Months Days Hours (Month, Day, Year) 09-09-1949 Maryland Director 61 212-50-0122 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 X No MD Anne Arundel 0denton 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 813 Quartz Flake Court 21113 United States Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 K Married 1 X Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: "natural", 3 Widowed 4 Divorced Year or Dates White ed other than "natu event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) nd Mental Hygiene. marked other tha Loan Officer Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ of Health and Ment fitem 27 is marked rother traumatic e Francis Patrick Newman Louise Lillian Graham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Pamela A. Newman / Wife 813 Quartz Flake Court Odenton, Maryland 21113 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date . of . **=** . 1 Burial 2 X Cremation 3 Removal from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Arundel Crematory 01-21-2011 Odenton, Maryland 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.
Donaldson Funeral Home & Crematory, P.A.

Donaldson Funeral Home & Crematory, P.A. 21. Signature of Funeral Servi . Licensee . Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIAC ARRHYTHMIA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner CORONARY Sequentially list conditions, Examine in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence on). sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IE FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PARKINSON'S DISEASE 2 No 3 Probably 4 Unknown 1 Yes this certificate has been si al director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed death? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director. Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 Tes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🔟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) melen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MILLER 3900 31. Date filed (Month, Day, Year) State 21 Registrar

32. Registrar's Signature

LOCH PAVEN

BONCEVARD, BACTIMORE MOZIZIS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Waryland of Troat/12 Py 201 Hanksh and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nelson Month Francis 20 i January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** of Sinai Hospital Baltimere 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 - F Months Hours Min. (Month, Day, 6706 213-78-**Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 □ No MI 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or Funeral 21216 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married and Mental Hygiene. Is marked other than "natural", or þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Seconday (0-12) College (1-4 or 5+) Improvement 2 thyrade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Nelson James onnie 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 21213 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 📈 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, -21-2011 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 21202 23a. Part 1. Ent. The disease, or complicating that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, having the immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed. attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day signed by the a 2 No 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by LUCIAR 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown substance cocaine 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 2 No 1 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Inpatient 2 I ER/Outpatient 3 I DOA Other: မ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural injury 5 Pending Accident Investigation 24 hours after death Funeral Director: the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) RES-000 M.D. 10,2011 January 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MI

State Registrar . Registrar's Sigrature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day -Month 9:39 PM MAY IAN UMRY Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Y 1 □ M 2 X F Pennsylvania Director Yrs. 205-20-5169 83 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at 1 🛱 Yes 2 ☐ No MD Prince George's College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9405 49th Ave. 20740 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ₩ Widowed 4 Divorced Year or Dates marked other than "natur matic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 12 Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Cahoon Margaret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Jenkins / Daughter 9405 49th Ave., College Park, MD permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory: 1/20/2011 Beltsville, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician. pirator 25 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner monar Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this confidence. Cause (Disease or iinjury that initiated events resulting in death) Last ate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month Month Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available autopsy prior to completion of pause of death? __ Yes 1 Yes completed filled in by the funeral director, To Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steller

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JAN 2 1 2011

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10215

32. Registrar's Signature

			For State	State of	Marylan		artment of I		and M	lental Hy	giene		25 1 1 1 2m		
			Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year												
	Physicia			ms Oel	nser						Day	2011 2011	3. Time of Death 6:20 P M		
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1			Friends Nursing H	ome			Sandy				Mo	ontgom	ery		
	Funeral Director		377-30-1907	M 2 🖾 F 7.	Age (In yrs. Ia 82	est birthday) Yrs.	If Under 1 Year Months Days	I <u>f</u> Under Hours	24 Hrs. Min.	8. Date of Birt (Month Day Aug 6	1928	9. Birth Coun Wash	place (State or Foreign try) ington, DC		
-	how at	٦	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Loc	eation					1	I 0d. Inside City Limits		
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-	The Nor 2	٥	10e. Street and Number	<u>- 1</u>			10f. Zip Code				10g. Citizen o	of What Cour	ntry?		
Ī	n with	Funeral Director	17401 Norwood Ro	ad			208	360			Unit	ed St	ates		
	r deat ir iten iner r		11, Marital Status 1 □ Never Married 2 □ Married	12. Was Deceder Armed Force	s?_		Vas Decedent of H Yes, specify Cuba					ace - Americ lack, White,			
92	sarre ral", o Exam	d by	3 Widowed 4X Divorced	1 ☐ Yes 2 If Yes, Give Year or Dates		1	☐ Yes 2 No	Specify:			Speci	ify: Whi	te		
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ק ק	Hygie Hygie other	Be C	17. Father's Name (First, Middle, Last)	4		50	cial Worl		er's Name	e (First, Middle,			Organizatic		
Maryland	be Tip	인	James John	Willia	ns				len	Grace	Whit	•			
ary	and M and M is ma	- 1	19a. informant's Name/Relationship (Typ	e, Print)		19b. Mailin	g Address (Street	and Numbe	er or Rura	l Route Numbe	r, City or Town	, State, Zip (Code)		
Σ .	ealth m 27 ner tra	١,	Thomas Oehser/son				64th St	reet	Beth	nesda, 1					
ore.	ge la it of H if ite or oth		20a. Method of Disposition 1 □ Burial 2X Cremation 3 □ F	Removal from Sta		lace of Dispos emetery, crem	sition (Name of natory or other plac	ce)		Date	20c. Location	n - City or To	own, State		
Baltimore,	permit. Fage 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If firem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other (Specify) 21. Signer re of Funeral Service Licensee		Fi <u>na</u>		ney Crema						Maryland		
Ra	Depar Impor any ir			meo	M00	957 Ĝ	Name and Addre	Cren Heck	natio crott	on Servi	ice P. Clark	O. Bo	x 784 e, MD 21029		
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~ PI	h_sician/	6. 1	Immediate Cause (Final disease or condition			otic C	ardiovaso	cular	Dise	ease			Onset and Death		
	Medical Examiner		resulting in death)		as a consequ										
		jer	Sequentially list conditions, if my lating to immediate cause. Enter Underlying	Due to for	as a consedu	ience of t						-			
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população	ian an irial-tra	E	that initiated events resulting in death) Last	Due to (or	as a consequ	ience of):									
00	physician and the burial-transit	edical	- 0	i								-			
200	iding page as	₩/Z	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcor							234	Date of delive	en/		
Rox	atter d for u	iciai	in the past 12 months? 1 Yes 2 No	4 🗌 Pregnar	nt at time of d		Ectopic pregnand Other (specify) _	cy				Month	Day Year		
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7. E	igned be de	ò	Part II. Other significant conditions con Hypertension	tributing to deat	h but not resi	ulting in the ui	nderlying cause gr	ven in Part i					ne cause of death?		
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ecc ecc	e has ige 2 s	Completed					-			autop perfo	rmed?	prior to co death?	mpletion of cause of		
i z	tificat tor, pa	BeC	25. Was case referred to medical				26. P	ace of Deat	th (Check	1 Yes	2 X No	1 Yes	2 L No		
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101	After th	ate:	27. Manner of Death 1X Natural 5 □ Pending	28a. Date of i (Month,	njury Day, Year)	28b. Time of injury	28c. Injur work	y at	- 1	28d. Describe h	ow injury occu	ırred			
SION	ctor: /	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of	Injury - At ho	me. farm. stre	M 1 L	Yes 2 🗆	-	28f. Location /S	treet and Num	ber or Rural	Route Number,		
DIVISION Falor Attendir	Saffer Direction by		4 Homicide determined		etc. (Specify,		,,			City or Tow		ibor or riord	riodio ivanisol,		
1 Florenit	t hour unera	Medical	29a. Certifier 1 X Certifying Physic (Check 2 Medical Examine										d. use(s) and manner stated		
4	The properties of Action 19 reported in the law requires that the action control within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Me	only one) 3 Certifying Nurse 29b. Signature and title of certifler					e time, date		e, and due to the		manner as st	ated.		
٩	Z ≥ 6 8		LOON	usun			D397				-	red (Month, I			
			30. Name and address of person who co		f death (Item	23a) (Type, P			-			-1 10			
			Christopher J. May		,	Princ	e Philip	Driv	e S	uite 20	7 Oln	ey. Ma	20832 Tyland		
	Stat	te	31. Date filed (Month, Day, Year)	32. Regi	strar's Signat	ure	arked						_		

DHMH 17 Rev 7/2009

11-00			Please Type or Print in Black Indelible I				ble.						
Char	les William	Pin	o, Jr. State of Maryland / Department of Certificate of Certificat		nd Mental H		2011						
	Physici		Registrar 1. Decedent's Name (First, Middle,Last)	Bodin		Reg. 2. Date of Death		3. Time of Death					
Med	lical Exami	iner	Charles William Pino, J		and section of Death	Month D January 19,		1240 hrs					
N			Facility Name (if not institution, give street and number) Doctor's Hospital	Lanham	or Location of Deatl	1	4c. County of Death Prince George						
	Funeral		5. Social Securify Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Ye			MM/DD/YYYY) 9. Bird						
3	Director		unkn₁⊠м 2□F 45 yr	s. Months Da	ys Hours Mir	06/03,	/1965 Co	untry) MD					
Bo	any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loca	ition		<u> </u>		10d. Inside City Limits					
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	death or item must b	Funeral	1 Yes 2 X No		an, Mexican, Puerto	Rican, etc.)	White, etc.						
	rs after ural", miner	þ	or Dates:	Yes 2 X N	o specify: ation (Give kind of	work done	specify: White one 16b. Kind of Business/Industry						
	72 hour	Completed			fe. DO NOT use ret			idd3ii y					
	9036 within iene. er tha	dmo		abled			N/A						
	21215-0036 Muld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Co	17. Father's Name (First, Middle, Last) Charles William Pino			e (First, Middle, Mai ane Eli	_{den Surname)} zabeth Co	stello					
	212 nould b d Ment is mark	To E		-	eet and Number or	Rural Route Numbe	er, City or Town, State,	Zip Code)					
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		Angela M. Walker / Sister 600 Walker Drive, Houma, LA 7036 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or										
	Baltimore, bermit. Pages I an Department of He important: If ite		1 Burial 2 Cremation 3 Removal from State crematory or o Final Jo	ther place)		4/2011	Woodbine						
	altir mit. Pa sartmer sortan	(1)	4 Donation 5 Other Specify: 21. Signature of Funeral Service LicenseeDonota Marshall 22.	Name and Addre	ss of Facility		<u> </u>						
		10	() aute W. Marshall	PO Bo	ox 1413,	<u>Baltim</u>		21203					
	Physician \/Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line. MARCOTTC: (MORBILLINE)		1 10	or respiratory arrest,	, shock, or heart	Approximate Interval Between Onset and Death					
W	Examiner		Immediate Cause (Final disease or condition resulting in death) a. NARCOTIC (MORPHINE) Due to (or as a consequence of):) Intoxi	cation								
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	in of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be ex After this certificate has been signed by the attending physician luneral director, page 2 should be detached for use as the burial.	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the 2 Female 23c. If yes, outcome of pregnancy 1 Live birth 2 Female 23c. If yes, outcome of pregnancy	etal death 3	Ectopic pregna	ancy	23d. Date of delivery Month D	ay Year					
	DX 6	sicia	past 12 months? 4 Pregnant at time of death 5 0	ther (Specify)									
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	fital sician: is certification	å	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ✓ ER/Outpatient		Other Nursir	only one) ng Home 5 Re	sidence 6 Other:						
;	of V ng Phy After th	5	27. Manner of Death 28a. Date of Injury (Month Day Year)		ury at Work?	28d. Describe how							
	SiOn ttendi death. ctor: /	atio	Natural 5 Pending Pending Investigation Fd 1-19-11 Fd 12:2	Z S pm	Yes 2 🗶 No	unknowi							
	Divisior spital or Attend hours after death uneral Director: y filled in by the	Certification:	Suicide Suicide Graph Could not be determined Suicide Graph Could not be determined Suicide Graph Could not be determined Graph Could not be determined Graph Could not be determined Graph Could not be determined	**	-	28f. Location (Stre or Town, State unknown	e)	al Route Number, City					
	Hospi 24 hou Funer tely fil		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occu	rred at the time,	date and place, and	due to the cause(s) and manner as state	d.					
	To the within To the comple	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigal and manner stated.										
		2	29b. Signature-and title of certifier		.M.E.		9d. Date signed <i>(Mon</i> lanuary 20, 2011	ui, ∪ay, rearj					
,	_		30. Name and address of person who completed cause of death (Item 23a)	1									
Iperd	3.				Street, Baltimo	re, MD 21223							
4	St Regist	ate trar	31. Date filed (Month, Day Year 1 2011 32. Redistrar's Signature A.	arke									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #5 Per FH Coll 1 / 25/2011 Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 Pena Marie Louise 12:35 PM January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist 9. Birthplace (State or Foreign Country) Mary land If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Days 1 🗆 M 2 🙀 F (Month, Day, Year) 2/10/1926 84 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Timonium 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21093 207 E. Timonium Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed Specify. 3 X Widowed 4 Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15, Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James W. Comegys Marie Knust 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4611 Piney Grove Road Reisterstown, Maryland 21136 Dennis Pena / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. 1/21/2011 Timonium, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Eugeral Service Licenses 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ ARDIONYO disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner sate has been signed by the attending physician and page 2 should be detached for use as the burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this confined to the Funeral Director. Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 🕅 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? potient 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1XX Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier RIZS 4rms 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Jan. 17, 2011 Month Physician/ Prince Nancy 1125 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Howard County General Hospital Columbia Howard Social Security Number If Under If Under 24 Hrs. 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days Min Sept. 16 1934 1 □ M 2 🔽 F 214-30-5421 **Director** 76 Usual Residence of Decedent 28a-f shov 10a, State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💂 No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 105 Oak Springs Drive 21060 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give 1 ☐ Yes 2 ☑ No Specify: and Mental Hygiene. White Specify: Completed 3 X Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Loan Officer Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Beachamp Lambert Margaret permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert R. Prince (son) Flora Lane, Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Glen HAven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2011 Glen Burnie, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stallings Funeral Home, P.A. <u>3111 Mountain Road, Pasadena, MD 211</u> 23a. Part I. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one clause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death regative Physician/ Gram bacterenia disease or condition Medical resulting in death) Due to (or as a conse vience of): Examiner traci Urinas. Sequentially list conditions, if any, leading to immediate Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be described. Exam Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Year Pregnant at time of death a 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 🗆 No 1 \square Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 2 🗌 No 1 Tes Accident Investigation Suicide Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, gearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year)

Jan. 17, 2011 29b. Signature and title of certifier 200 66515 Jan 11 Lols

State Registrar

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Kawal

32. Registrar's Signature

10710 Charter Dr. Suite 310 Columbia MD 21044

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible $_0 \cap \ \cdot\ $	01149
State of Maryland / Department of Health and Mental Hygiene	01143

Timothy Alien Tie		1-For State Certificate of Death Reg. No.	
Physicia	n/	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year	3. Time of Death 1340 hrs
Medical Examin		Timothy Allen Pickett 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	1340 1115
		455 E. Main Street Westminster Carroll	
Funeral Director		- Land 1	
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-003 I within giene.	Ĕ	17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname)	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than cevent, the Medica	Be C	Samuel G. Pickett Jr. Brenda Dearing	
hould I		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z	
and 2 sho ealth and central is fraumati		Samuel Pickett-brother 2472 Salem Bottom Rd., Westminster 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or To	
Baltimore, permit. Pages lan Department of Hea Important: If ites injury or other tr		1 Burial 2 Cremation 3 Removal from State South Carroll Crem 1-14-11 Winfield, 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	
Balt permit. Depart Impor	ı	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fletcher Funeral H 254 E. Main St., Westminster, MD	
Physician	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and
/Medical Examiner	1	Immediate Cause (Final disease or condition resulting in death) a. Addisonian Crisis Due to (or es e consequence of):	Death
	۱.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
executed al-transit	E E		
O, e be ex	Medical	▼ UNPENDED □ AMENDED 23a,27 per me g913 3-16-11 vt	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 23d. Date of delivery Month Day	y Year
The der	ᇍ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the	e cause of death?
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Rec The la icate ha	틹	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes	2 No
ital iician: s certif rector,	8	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other, Nursing Home 5 Residence 6 Other. S	Scone
of Vij	۹	1 Ves 2 No 1 Impatient 2 ENOutpatient 3 DOA 4 Nursing Home 5 Residence 6 Votreil S 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred	-
ion trendin leath. tor: A	턞	1 X Natural 5 Pending 2 Accident Investigation 1 Yes 2 No	
Division of Vital Records pital or Attending Physician: The law requireral Directorarh. After this certificate has been filled in by the funeral director, page 2 should	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural or Town, State)	Route Number, City
Divisior To the Hospital or Attend within 24 hours after death To the Functal Director: completely filled in by the	Medical Co	29a. Certifier (Check only one) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 39a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 39a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 39a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
To cor	ğ	and manner stated. 29b. Signature and the of certifier 29d. Date signed (Month)	, Day, Year)
4		January 14, 2011	
Ψ		30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
Sta Registr	te ar		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 0612P M Robert Edward Pippin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death ALTIMORE n/a tospital AGNES If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 🗆 F 212-76-0280 Director 50 21/27 1968" Washington DC Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show important: If item 27 is marked other than "natural", or Items 23a or 28a-f show important: or other traumatic event, the Medical Examiner must be notified at anne. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Catonsville 1 🗌 Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6224 Frederick Road 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 0 Sales Contractor Heavy Equipment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Harold J. Pippin Shirley Charles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marguerite D. Pippin / Wife 6224 Frederick Road, Catonsville, Maryland 21228 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) New Cathedral Ceme. 1/21/2011 Baltimore, Maryland 21 Si nature of Funeral Service License 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ heloseleso disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Dire to (or as a consequence of): cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. ied by the attending physician and detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 🗌 No Other: ٩ 1 Inpatient DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 3308 Name and address of person who completed cause of death (Item 23a) (Type, Print) craa St Agno Caton 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

2036 hrs 4c. County of Death **Baltimore County** 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? 14. Race - American Indian, Black 16b. Kind of Business/Indus Number or Rural Route Number, City or Town, State, Zip Code) 20c. Location - City or Town, State MI Approximate Interval Between Onset and Death Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ✔ Unknown 24b. Were autopsy findings available prior to completion of cause of 1 🗸 Yes 2 No the Hospital or Attending Physician: Other₄ Nursing Home 5 Residence 6 ✔ Other: Scene Certification: subject exposed to cold 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Rollwin Rd. 21244 Windsor Mill, Balto. Co, Md. CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 54 Medical Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 13, 2011 rson who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) State 32. Degistrar's Signature Registrar

3. Time of Death

DHMH 17 Rev 1/2001 **OCME 2006**

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Martha Robertson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore NA 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 06 - 13 - 30 1 M 2 XF Days Min. 231-34-4951 Hours Country) **Director** 80 NC Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location event, the Medical Examiner must be notified at **Funeral Director** 10d. Inside City Limits MD NA 1 X Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Bellona Avenue 6000 21212 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. African Armed Forces?

1 Yes 2 X No
If Yes, Give ō þ 1 Never Married 2 Married filed within 72 hours after 1 ☐ Yes 2 ☐ No Specify. Specify: American "natural", Completed 3 Nidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) NA Waxter Center Environmentalist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o ဂ္ Oscar Williams Margaret Staton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21239Peggy Bailey-Niece 6115 Edlynne Road Baltimore, Maryland other altimore, 20b. Place of Disposition (Name of cometery crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1XXBurial 2 Cremation 3 Removal from State Mt. Zion Cem. injury or 01 - 25 - 11Lansdowne, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylle Funeral Home P.A. 21. Signature of Funeral Service in risee any in 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ o cordid my disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Day ias been signed by the 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 No Yes 25. Was case referred to medical B B 26. Place of Death (Check only one) 2 No Other: 1 🗌 Yes Certificate: To 1 ☐ Inpatient 2 SER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) : After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending thin 24 hours after death.

the Funeral Director: All ompleted filled in by the fu 1 ☐ Yes 2 ☐ No Investigation Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Fertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24

To the F

complet 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 100 40059540 5601 Loch Raven Blvd. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Good Samaritan Hospital Baltimore, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ The1ma Μ. Rogers January 20^{Year} 6:00pm Medical 4a, Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Transitions Health Care Sykesville Carrol1 Social Security Number If Under 1 Year | If Under 24 Hrs **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 F 215-34-0398 Hours Min Dec. 22 Year 1936 74 Director Usual Residence of Decedent or 28a-f show within 72 hours after death with the Maryland 10a State 10c. City, Town or Location the Medical Examiner must be notified at Director 10d. Inside City Limits Carrol1 1 Yes 2 Tr No Sykesville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 7241 Gaither Road 21784 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. "natural", or 1 Never Married 2 X Married Black, White, etc. ģ 1 ☐ Yes 2 💢 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Completed 3 ☐ Widowed 4 ☐ Divorced Specify White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72. In and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Medical Secretary Clerical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Conley Lewis Cecile Esther Bennett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shu Department of Health ar Important: If item 27 is Mr. Coman H. Rogers (Spouse) 7241 Gaither Road Sykesville. MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place ö injury Lake View Mem. Park 1/21/2011 Sykesville, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Licensee Herry M00764 PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph sician/ omentic disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) ause (Disease or iirijur) the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death Year 5 Other (specify) 1 Yes 25 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? ØNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 1 🗌 Yes Other 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 01: 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TAO I A. MATHINUUD 19, Mily e Road Wellmin 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Jann 6:50 M Kay Dalgaard Reed 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Randallstown Seasons Hospice at Northwest If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number **Funeral** Mar 16, Yel 931 Months Hours 79 NJ Director 164-26-9379 Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location death with the Maryland Director 1 🗆 Yes 2 No West Friendship MD Howard 10f. Zip Code 21794 10e. Street and Number 10g. Citizen of What Country? Funeral 12478 Indian Hill Drive USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. 11. Marital Status Armed Force Black, White, etc. 1 Never Married 2 Married Yes 2 No þ Maryland 21215-0036 hours after 1 Yes 2 No Specify: White If Yes, Give Year or Dates Specify: Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Telephone Operator 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Curdt Edith Ione V. Dalgaard permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1304 E. 9th St., Eddystone, PA 19022-1428 Ms. Andrea Dalgaard (Sister) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State All County Cremation 1/21/2011 Sykesville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Licensee tradust thought spendert PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final yelody Physician/ month disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) ending physician are use as the burial-Physician/Medical e Hospital or Attending Physician: The law requires that the death certificate be regardours after death.

24 hours after death.

Permeral Director: After this certificate has been signed by the attending physicial physicial in by the funeral director, page 2 should be detached for use as the brunkleted filled. P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1401 P. K. Maj 1 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 🗌 No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division of Vital сопріете within 2 To the F

> State Registrar

Medical

29a. Certifier

(Check

only one

29b. Signature and title of certifier

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

ORIGINAL

32. Registrar's Signatur

tercifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Acia Now Bluk

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 19, 2011 6:05 A M Nancy Paige Redman Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1635 Shannon O Circle Anne Arundel Severn Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Days Hours Min. December 3, 3 ear) 1943 Virginia **Director** 223-58-3128 67 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 ☐ Yes 2 🛣 No Maryland Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1635 Shannon O Circle 21144 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Robey Lawhorn Helen Curry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Redman/Husband 1635 Shannon O Circle, Severn, Maryland 21144 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State January 1 X Burial 2 Cremation 3 Removal from State Laurel, Maryland Ivy Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2011 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Physician/ Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760

	per C	MO1	386 Dona 1411	Annapolis Ro	Home & Cre ad, Odentor	ematory, i, Maryla	nd 21113			
Examiner	23a. Part Emer the disease, or on shock, or hear failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Unidentifying Cause (Disease or linjury that initiated events resulting in death) Last	a. Chronic Re Due to (or as a conseq c. Due to (or as a conseq Due to (or as a conseq Due to (or as a conseq C. Due to (or as a conseq	nal Failu: uence of): ia uence of):		c or respiratory arrest,		Approximate Interval Between Onset and Death			
Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregnn 1 Live Birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 🗌 Ector	oic pregnancy (specify)		23d. Date of de Month	elivery Day Year			
ted by Ph	Part II. Other significant conditions of Tracheostomy	contributing to death but not re	sulting in the underlyi	ng cause given in Part I.			o the cause of death? Probably 4 🗆 Unknown			
Comple			_	prior to death?	itopsy findings available completion of cause of					
e e	25. Was case referred to medical examiner?			26. Place of Death (Che	eck only one)					
101	1 ☐ Yes 2 ₹ No	Hospital: 1 Inpatient 2 I	ER/Outpatient 3	DOA Other: 4 \(\sum \) Nursing I	Home 5 XResidence	6 ☐ Other (Spec	cify)			
ficate:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation		28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	jury occurred					
Medical Certificate:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or City or Town, State)									
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as some only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as some only one) 1 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as some only one)										
-	29b. Signature and title of certifier	//	:	29c. License number	29d. I	Date signed (Mont	h, Day, Year)			
D36900 January 20,										

DHMH 17 Rev 7/2009

State Registrar

Krishan K. Singal, M.D., 3708 Mountain Road, Pasadena, Maryland 21122

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Charles Barton Reppert 2011 January 6:55 pm M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ Months Days Hours Min. New York 62 Director 068-38-7637 14 Nov Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at with the Maryland Director MD 1 ☐ Yes 2 🏹 No Montgomery Silver Spring 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1417 Glenallan Ave. 20902 United States within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2XXNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: White Specify: "natural" Completed 3 Widowed 4XXDivorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Journalist Independent Be be filed 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) is marked o ည Charles Reppert Charlotte Putnam . Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2. Department of Health Important: If item 27 any injury or other troones. Christy Sacks / Sister 138 Remsen St. Apt. #1-A, Brooklyn, NY 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 TCremation 3 Removal from State Chesapeake Crematory 1/20/2011 4 Donation 5 Other (Specify) Beltsville, MD Signature of Funeral Service bicensee 22. Name and Address of Facility Rapp Funeral and Cremation Services Gist Ave., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Dea Interval Between Immediate Cause (Final CARDIOMYOPATHY Physician/ DILATED disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transil The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year signed by the at d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed funeral director, page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 \(\subseteq N the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu death Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number

State Registrar

31. Date filed (Month, Day, Year)

908 DARNESTOWN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NELSON L.

Krew, PH 151 CIAN

ROAD, SUITE D

D-4386

NORTH POTOMAC,

JANUARY 18, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #3 Per PHY G911 1/25/2011 JH.

			For State Registrar	State	f Marylai	nd / Depa <i>Cei</i>			lealth a D <i>eath</i>		ental H		ene . No. 2 ()		n	157
		1	Decedent's Name (First, Middle,	Last)							2. Date of		E-0 10	E L	3. Time of 5:45	Death
	Physici /Medi		PAUL EDWARI	REVELL							JANUA	RY	14, 20	Year L1	2.45	A M
¥	Examir		4a. Facility Name (If not institution,	give street and nu	mber)		4b. City,	Town, or	Location of				4c. County of			
			919 Country Clu	ıb Road			Hav	re d	le Gra	ace			Harf	ord		
	Funeral			6. Sex 1 X M 2 ☐ F	7. Age (In yrs	. last birthday)	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of (Month,	Birth Day, Y	ear)	9. Birth	olace (State o	or Foreign
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	pue *		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation							1	10d. Inside C	ity Limits
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	Jeath ns 23	era	11. Marital Status	12. Was Dec	edent Ever in l	U.S. 13. 1			spanic Orio	gin? (Spe	cify Yes or		USA 14. Race	- Ameri	can Indian,	
(0	r Her	by Funeral	1 ☐ Never Married 2 X Marrie	Armed Fo	2 No		_		ispanic Orig n, Mexican	i, Puerto l	Rican, etc.)			, White,		
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21215-0036	72 hours after death with the Maryland natural', or items 23a or 28a-f show dical Exacultat right by Indiliad at	Completed	15. Decedent's (Specify only highest			16a. Dece			ation during most	t of workir	20	16	b. Kind of Bus	iness/In	dustry	
2	within ene. than "	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT u	se retired)	(0/ 1/0/////	'9					
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and	be fi	Be	17. Father's Name (First, Middle, L										iden Sumame)		
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Maryland	d 2 sh h and 7 ie m traum		19a. Informant's Name/Relationsh										ity or Town, S		- 4	1078
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show my injury or other traumatic event, the Michael Examination of the profiled at 2008.		Joyce Revell /	Spouse	20b.	Place of Dispo	sition (Nar	me of		Road,	Havr	e de	e Grace	ity or T	arylan	<u>.d</u>
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Baltimore,	permit. Pag Department Important: I any injury o		4 Donation 5 Other (Sp. 21. Signature of all Service M		Hi	11top	Servi	CA C	om L	.–18 – .	11	T	wson,	Mar	yland	
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	/Medical		disease or condition resulting in death)	a	(or as a conse		(1((0	ince	1					10 mor	~Ths
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Box	ath c	Physician/Me	23b. Was decedent pregnant in the past 12 months?		irth 2 Fet	al death 3	Ectopic pr						23d. Date Mon			Year
	the g	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊟Pregr 9⊟Unkn	ant at time of own	death 5L	Other (sp	оөсrfy)				_			,	
P.0	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	'Ph	Part II. Other significant condition	s contributing to d	eath but not re	sulting in the u	nderlyina c	ause give	en in Part I.		23e. D	id tobac	co use contril	oute to t	he cause of o	death?
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₹	Physicien: r this certifica ral director, p	To B	examiner?	Hospital:	Inpatient 2	☐ ER/Outpatien	t 3 DC	Othe	261	- 1-1-1	Check on		e 6 □Othe			
o	ding Physicien: The interment this certificate hadineral director, page		27. Manner of Death	28a. Date	of Injury	28b. Time of		28c. Injury Work	4 🗀 140				injury occurre	. ,	(y)	
ion	ath. r: Aft	atlo	2 ☐ Accident 5 ☐ Pending investiga		th, Day Year)	Injury	М		(? Yes 2 ☐ f	No						
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Ö	tal or s aft al Dii	Certification:		build	rig, etc. (opec						City of	rown, s	olale)			
	tospi thou uner		29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the xaminer: On the b	best of my kn	owledge, death	occurred	at the tim	e, date and	d place, a	ind due to t	the caus	se(s) and man	ner as s	tated.	-1
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	0/16)	and man	ner stated.	and of HI				5000116						*1
3	To To	-	29b. Signature and title of certifier	fr. O.	MD			o. License D <i>OD C</i>	480	50		29d.	Date signed		uay, Year)	
			fresh C) mm			1						1			
		III	30. Name and address of person w	nkla, mo	se of death (Ite	m 23a) (Type, S: Parl	Print) م	+ #	400	A6	erde	en	MO 2	100		
. 9	Sta	te	31. Date filed (Month, Day, Year)	1 - 001 /	egistrar's Sign		~						-			
1	Registr	-	JAN 2 1 2	01 2	Lacing.	A. 200	Carta									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 Jan. Kathleen Elizabeth Rich 10:40-AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Dunda1k 7947 Charlesmont Road 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 4,1968 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 M 2 X F 220-98-9636 Maryland **Director** Yrs Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Dunda1k 1 Tyes 2 No MD Baltimore 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21222 United States 7947 Charlesmont Road within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 0 by 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural" 3
Widowed 4
Divorced White Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the 2 should be filed with h and Mental Hygien 7 is marked other th Restaurant 12 Years Waitress traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joann Perry Joseph John Galoni, Sr. 19a. Informant's Name/Relationship (Type, Print) n, State, Zip Code) 19947 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Mrs. JoAnn Lee Flack (Mother) Health 28008 Avalon Dr. Georgetown, DE 27 Page 1 and 2 item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot once. 1 Burial 2 X Cremation 3 Removal from State Service Corp 1/20/2011 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, MD 21222 21. Signature of Tun 23a. Part 1. Enter the disease, or complications that caused the der h. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Day 5 Other (specify) Month Year Pregnant at time of death 1 L Yes 2 by the detached Part II. Other significant conditions contributing to death but, e given in Part I. 23e. Did tobacco use contribute to the cause of death? signed þ pe 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate Yes 2 No 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: မြ 5K Residence 6 Other (Specify) 1 Inpatient 2 I ☐ Nursing Home ER/Outpatient this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at s after death.
I Director: After to in by the funeral Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the Dest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, D

1005

Point

Blyd

Baltimore, UD 2/224

cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- For Amend Item 26 per ver Registrar	b, g91 Cer	1 01/21/2 tificate of D	011dhb eath	ientai riy	Reg. No. 1	1011	01150
	Physicia	n/	Decedent's Name (First, Middle, Last) Mary Louis	e F	Rowe		2. Date of De	ath Day	2011 Year	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or I	Location of Death	Jan	$\neg \neg$	ZUII ounty of Death	8:31 PM
الممي			123 Chell Road		Joppa				larford	
	Funeral Director		5. Social Security Number 214-28-6987 Usual Residence of Decedent 6. Sex 1 □ M 2 ▼ F 7. Age (In yrs. In proceeding to the second to the se	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birl (Month, Da May 21		Count	lace (State or Foreign ry) Land
and	show	ro		ty, Town or Loc	cation				1	0d. Inside City Limits
Mary	28a-f	irec	MD Harford		Joppa					1 ☐ Yes 2 🛣 No
ith the	23a or st be r	Funeral Director	10e. Street and Number 221 Doncaster Road		10f. Zip Code	21085		J	en of What Coun nited St	,
eath v	items er mu	Fune	11. Marital Status 12. Was Decedent Ever in U. Armed Forces?	S. 13. V	Vas Decedent of His f Yes, specify Cuban	panic Origin? (Spe	cify Yes or No-		. Race - America	an Indian,
21215-0036 within 72 hours after death with the Maryland	ital Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ted by	1 Never Married 2 Married 1 Yes, 2 No 1f Yes, Give Year or Dates.		Yes 2 No		nicali, etc.)	Sp	Black, White, e	White
15-1	ın "nat Medica	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	dent's Usual Occupa kind of work done du O NOT use retired)	tion uring most of worki	ng	16b. Kind	of Business Inc	lustry
212 within	giene. ner tha t, the l	S	Elementary/Seconday (0-12) College (1-4 or 5+) 12 Years		Homemaker				Own Home	2
Maryland 2 should be filed	ental Hygred oth	To Be	17. Father's Name (First, Middle, Last)			18. Mother's Name			rname)	
arylia Pould b	and Me	ľ	William Lakin 19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street ar	Louise			wn, State, Zip C	ode)
	1 + 2 + 1		Maria L. Winiarski(Daughter)	123	Chell Roa	ad Joppa	, Mary	land	21085	
Baltimore, permit. Page 1 and	nt of H t: If ite / or oth		1 🗆 Burial 2 🖾 Cremation 3 🗀 Removal from State	cemetery, crem	sition (Name of natory or other place	9)	Date 7/2011		ation - City or To	
Baltin	Department of Important: If any injury or once.		4 Donation 5 Other (Specify) H1. 21. Signature of Funeral Service Licenses		Service Co Name and Address Duda-Ruck				wson, M	
n 8			Jul a Jone		7 <u>922 Wise</u>	Ave. D	undalk,	Mary	$\frac{1}{2}$	1222
			23a Part 1. Enter the disease, or complications that caused the deal shock, or heart failure. List only one cause on each line. Immediate Cause (Final	th. Do not ente	4		or respiratory ar	rest,		Approximate Interval Between Onset and Death
	nysician/ Medical		disease or condition resulting in death) a. Due to a a conseq	Sive juence of):	Lymp	roma			15	months
E	xaminer	er	Sequentially list conditions, b.		9 1					
pet	nsit	Examine	If any keeping to immediate the consequence of the	tience of):					-	
executed	physician and the burial-transit	I Ex	that initiated events c. Due to (or as a conseq	uence of):						
7760 ficate be	physic the bu	edica	d							
Box 68 death certi	ne attending ed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregnat 1 ☐ Live Birth 2 ☐ Fetter 1 ☐ Pregnant at time of 9 ☐ Unknown	aldeath 3	Ectopic pregnancy Other (specify)	/		23	d. Date of delive Month	ery Day Year
cords, P.O. law requires that the	n signed by	by	Part II. Other significant conditions contributing to death but not res	sulting in the u	inderlying cause give	en in Part I.			_	e cause of death? pably 4 🗌 Unknown
DIVISION OT VITAI RECORDS, tal or Attending Physician: The law requires	has le 2	Completed						psy ormed?		osy findings available mpletion of cause of
tal F Sian: T	certificate rector, pag	BeC	25. Was case referred to medical examiner?			ce of Death (Check				
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DIVISION Atte	24 hours after death. Funeral Director: After this certific eted filled in by the funeral director,	I Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At h building, etc. (Specification)	ome, farm, stre	eet, factory, office		28f. Location (\$ City or Tov		Number or Rural	Route Number,
he Hospi	within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier 1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination only only only only only only only on	on and/or invest	tigation, in my opinior	 death occurred at 	the time, date a	and place, a	nd due to the cal	ise(s) and manner stated.
D top	with To 1		29b. Signature and title of certifier	D.	29c. License	number 45391			signed (Month, I	
			39 Name and address of person who completed cause of death (Iten	n 23a) (Type, P	Print) Atwood	d Roac	1 # 20	0,8	el Air	MD21014
	Sta Registra		31. Date filed (Month, Day, Year) JAN 2 1 2011 32. Registrar's Signa A.	face	W.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Saltzman 3: 20 PM Norman 18 January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours 1 🗶 M 2 🗆 F **Director** Yrs. 10/06/1920 Country) 215-16-2286 90 MD Usual Residence of Decedent fshow should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a. State 10b. County Examiner must be notified at Director 10c. City. Town or Location 10d. Inside City Limits 23a or 28a-1 BALTIMORE 1 Tes 2 TN No OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9300 COUNTESS DRIVE 21117 USA "natural", or items 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces by Black, White, etc. 1 Never Married 2X Married 2 | No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 4 Divorced Specify: WHITE injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 OWNER PICTURE FRAMES Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 OSCAR SALTZMAN GERTRUDE WEINBERG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau JANET SALTZMAN/WIFE 9300 COUNTESS DRIVE, OWINGS MILLS, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State ARLINGTON CHIZUK 4 Donation 5 Other (Specify) 1/20/2011 BALTIMORE, MD 21. Signal re o Funeral Sorvice Li ens e 22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BladdeR Physician/ cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of). Exami The law requires that the death certificate be executed the attending physician and thed for use as the burial-tran: that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Year s been signed by the s 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 🗹 No 3 Probably 4 Unknown 1 🗌 Yes Were autopsy findings available prior to completion of cause of cate has by page 2 s 24a. Was an autopsy performed death? certificate 1 ☐ Yes 2 ☐ No 2 W No Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be funeral director. 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending Natural 1 🗌 Yes 2 🗌 No Accident Investigation 24 hours after deat Funeral Director: completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 45 Rajapannem.D 00057465 1/19// 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
N-S'RAY APA KSC, M.D: 2835 SmiTh AV. S-2=3- Baltimore, MD. 2)209

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Amend 4a, per MD G911 1/21/11 TT Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 01 2011 14 8:10a. Smith Mae <u>Lillie</u> /Medical Facility Name (If not institution, give street and number)
5411 Mayview Avenue
Cood Samaritan Hospital 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore If Under 1 Year | If Under 24 Hrs Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) 1 □ M 2 👿 F 80 Director 212-34-5877 09 25 SC 30 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Madical Examinar inust be notified at X Yes 2 □ No Director Baltimore MD NA 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. Funeral 21206 <u>5411 Mayview Ave</u> 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite may lajury or other traumatic event, the Marical Examina and. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ▼No ģ Specify. Specify: Black 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker House 8th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Radus Garris Powell Garris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4204 Oakford Ave, Baltimore, Md 21215 Elizabeth Evans-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State M☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 1/22/2011 Woodlawn, Md Signature of Funeral Service Licenses 22. Name and Address of Facility
March F/H West 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Graun 21215 4300 Wabash Ave, Baltimore, Md Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Peritonitis disease or condition resulting in death) /Medical Due to (or as a consequence of): 10days Examiner End Stage Renal Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Diabetes Mellitus and Hypertension Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. **Other signific**an**t conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 🗷 No 2 🗆 No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🗷 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 X Natural 5 Pending 1 ☐Yes 2 ☐ No investigation after death 2 Accident filled in by the 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral L cai 29a. Certifier 1 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Thomas Wilcon MD January 18,2011 D40277 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILSON, M.D. 5601 Loch Raven Boulevard, Baltimore MD 21239 Inomas 31. Date filed (Month, Day, Year)

JAN 2 1 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

				State of Maryla				-	•	•
			For State Registrar	· · · · · · · · · · · · · · · · ·	•	rtificate of E		, 0	NG 0	01162
	Physicia	n/	1. Decedent's Name (First, Middle, Las	it)	. 9			2. Date of Death Month	Day Year	3. Time of Death
	Medic	al	4a. Facility Name (if not institution, give		>++	1		Janvary	16 201	
1	Examin	er	11	PITAL		4b. City, Iown, or	Location of Death	RE '	4c. County of Dea	th
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yr	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth	g. Bir	thplace (State or Foreign
	Director		218-36-1247	□ M 2 X F 70	Yrs.	Months Days	Hours Min.	(Month, Day, Ye	40	ountry) MD
	show	5	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
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	h the la or 2	Funeral Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	ountry?
	th wit ms 23 must	ner	2508 Marbourne	Ave	ue Ia		230	:N-	U.S.A.	
(0	or ite		11. Marital Status1 ☐ Never Married2 ☐ Married	Armed Forces?	0.5.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	Rican, etc.)	14. Race - Ame Black, Whit	
8	ırs aftı ıral", I Exar	ed	3 Vidowed 4 □ Divorced	1 Yes 2 No If Yes, Give Year or Dates.		1 🗆 Yes 2 🔀 No	Specify:		Specify:	Black
21215-0036	be filed within 72 hours after death with the Maryland antal Hygiene. Red other than "natural", or items 23a or 28a-f show te dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by	15. Decedent's E (Specify only highest gr		(Give	dent's Usual Occup kind of work done o	ation during most of work	sing 16	b. Kind of Business	Industry
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ylaı	should be file n and Mental P 7 is marked o raumatic eve	잍	Earl Amos				Mary Fo	ots		
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வி	t and 2 sl f Health a f tem 27 is		Aretha Amos-Da 20a. Method of Disposition		b. Place of Dispo		rne Ave	Date 20	nore. Mo	
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Baltimore,	permit, Page 1 a Department of I Important: If ite any injury or of	П	21. Signature of Funeral Service Licen			2. Name and Address arch F/F		72011	Dartinor	e, ma
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	ia come a		23a. Part 1, Enter the disease, or com shock, or heart failure. List only of Immediate Cause (Final	plications that caused the dine cause on each line.	eath. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
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Box	the a	Physician/Med	1 Yes 2 No	4 ☐ Pregnant at time 9 ☐ Unknown	of death 5 L	Other (specify)			WOITH	Day Year
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0	spital	Medical	29a. Certifier 1 Certifying Phy	rsician: To the best of my kn	owledge, death	occured at the time	, date and place, a	nd due to the cause	s) and manner as st	ated.
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. within 24 hours after death. completed filled in by the funeral director, page 2 should be detached for use as the	Med		iner: On the basis of examina se Practioner: To the best of						
	With To 1		29b. Signature and title of certifier	5 - d - N1		29c. License	- 11	290	. Date signed (Mont	th, Day, Year)
			30. Name and address of person who		SICICO tem 23a) (Time		51853		MOVACY	16,2011
,			Michael S			South H	LTOOM	Street	Bathon	pre 21225
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sig						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month $11:42 a_{M}$ **Physician** 18 William L. Simms, Jr 1 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Hospital Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1√ M 2□ F 21740-4472 66 9-10-1944 MD Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c, City, Town or Location 28a-f show Examiner must be notified at Director 1X Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. ō 6201 Loch Raven Blvd 21239 , or items 23a USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Armed Forces?
1 XYes 2 □ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) is marked other than Sparrows Point Steel Maker 12th grade 2 yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည William L. Simms, Sr Bessie_Jacobs 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any Injury or other trau once. Diane Simms-Wife 6201 Loch Raven Blvd Balto, MD 21239 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest 27-2011 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses March East F/H Avenue 1101 E. North Balto, MD 21202 nelle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Autointibudy Physician arm /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760. physician Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.0. s been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No nas e 2 certificate ha 1 ☐ Yes 2 ☐ No 1 □Yes Division of Vital To the Hospital or Attending Physician: director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 No 1 ☐ Inpatient 2 区 ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 +1 Bund, Mr Martin 10 Garaa-31. Date filed (Month, Day, Year) 82. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 1-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 11:10 AM aniel 2011 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Adamstown
If Under 1 Year | If Under 24 Hrs. Buckingham's Choice odenuk 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days **X** M 2□ F Months Hours Yrs. **Director** 525-48-9477 83 Julv -28. 1927 New Mexico Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ne 23a or 28a-f ehov must be notified at MD Frederick 1 ☐ Yes 2▼ No Adamstown Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3200 Baker Circle 21710 United States Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. I XYes 2 No If Yes, Give Year or Dates: 1945-46 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1∭ Yes 2□ No Specify: White ģ Specify. "natural", 3 □ Widowed 4 □ Divorced (Unknown) leted other than "natu 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Compi Elementary/Secondary (0-12) College (1-4or 5+) Senior Official Federal Government 7 ie marked othe traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Sanchez Clara Armijo ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 i Thomas Sanchez / Son 101 Back Forty Loop, Williamsburg, VA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. 4 ☑ Donation 5 ☐ Other (Specify) Uniformed Sers. Univ. 1/20/2011 Bethesda. MD 21. Signature of Funeral Service Licensee Rapp Funeral and Cremation Services M00382 933 Gist Ave., Silver Spring, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac phock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** whocoson /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to annieciate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). physician and s the burial-transit The law requires that the death certificate be executed Exam resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Completed by Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 No 3 Probably 4 □Unknown DRESZME 24b. Were autopsy findings available prior to completion of cause of death? certificete has tirector, page 2 s 24a. Was an autopsy performed? 1∏ Yes 1 ☐ Yes 2 No After this certification, funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 42 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 1 ☐ Yes 2 ☑ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death.

Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after or To the Funeral Direct completely filled in by 4 Homicide determined ō Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier the L 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

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32. Registrar's Signature

Thomas

tradesion mp 21702

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Sh oh

31. Date filed (Month, Day, Year)

JAN 2 1 2011

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

Amend Item 2 State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. | | For State Registrar Reg. No. Date of Death 01/13/2011 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ VEL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ba allstown 10 and If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🛛 F Months 93 Yrs. Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 15a M()1 Yes 2 No nu 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 21215 items 23a US Pimlico Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. o 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black If Yes, Give Year or Dates. "natural", 3 ₩Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) ouse w Home other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 19a. Informant's Name/Relationship (Type, Print) Department of Health and Department of Health and Important: If item 27 is n agy injury or other traum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 54 9 p/to. 21218)aughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other 2 Cremation 3 Removal from State Randallstown -21-2011 Dor tion 5 Other (Specify) East Signature of Funeral Service Lice 22. Name and Address of Facility Marc 18. MD 21202 Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between k, or heart failure. List only one cause on each line. Onset and Death mediate Cause (Final Physician/ ing in death) 00 Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy ☐ Pregnant at time of death 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year ed by the a 9 Unknown 9 Unknown P.0. Part !!. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has perform 2 🗌 No Yes 2 No 1 🗌 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical of Vital 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide
Homicide 5 Pending work' Division 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death assumption and the cause (s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State 1 Registrar

DHMH 17 Rev 7/2009

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atricia Spearm	nan	State of Maryland / Departm		nd Mental Hy	giene	201	1 01166				
		Registrar	ate of Death			eg. No.	1 01100				
Physic Nedical Exam		Decedent's Name (First, Middle, Last)			Date of Dea Month	Day Year	3. Time of Death				
iculcul Exam		Patricia Ann Spearman 4a. Facility Name (if not institution, give street and number)	Ab City Town	or Location of Death	January 1	2, 2011 4c. County of D	2217 hrs				
		740 Poplar Grove Street Apt. 3-R	Baltimore	of Location of Death		4c. County of Di	eam				
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bin		ar If Under 24Hrs.	8. Date of Bir	rth(MM/DD/YYYY) 9.	Birtholace (State or				
Director		216-74-1667 _{1 M 2 F} 52	Months Da		1		reign Country) MD				
		Usual Residence of Decedent	Yrs.		00/11	71330	Codinity) 1-1D				
any		10a. State 10b. County 10c. City, Town	or Location				10d. Inside City Limits				
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Maryland 28a-f show 1 at once.	Director	10e, Street and Number	10f. Zip Code		1	0g. Citizen of What C	country?				
with the Maryland ns 23a or 28a-f sho be notified at once.	듑	740 Poplar Grove St. Apt. 3R	21216	·		USA					
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death or ite must	'n.	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	if Yes, specify Cuba	in, Mexican, Puerto R	ican, etc.)	White, etc					
s after ral", tiber	þ	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 No			Specify: B1	ack				
hours fratu Exam		15. Decedent's Education (Specify only highest grade completed) 16a.	Decedent's Usual Occupa during most of working life			16b. Kind of Busine	ss/Industry				
136 hin 72 e. than '	ple	Elementary/Secondary (0-12) College (1-4 or 5+)	ome Maker			Own Hom	e				
d with	Completed	17. Father's Name (First, Middle, Last)	The Harter	18.Mother's Name (First Middle M	Maiden Surname)					
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	J. C. Spearman		Dorothy							
21, ould b	T _o		b. Mailing Address (Stre	et and Number or Ru	ral Route Num	nber, City or Town, St	ate, Zip Code)				
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-7 ah. or other traumatic event, the Medical Examiner must be notified at once		DISLEI I	Yvette Spearman-Harris/ 2209 Hamiltowne Cir. Ros								
re, land Heal Heal		20a. Method of Disposition 20b. Place of	of Disposition (Name of ce ory or other place)	meterv	Date	20c Location - City	or Town State				
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Baltimore, MD 21215-00; permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other to injury or other traumatic event, the Med	1	21. Signature of Funeral Service Licensee		s of Facility AFA	/sten	hen D Lo	hrmann P.A				
E.E.S.s in		reducca recurren	8717 Gre	en Pastu	res D	r. Balto	,MD 21286				
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do no failure. List only one cause on each line.	ot enter the mode of dying	, such as cardiac or r	espiratory arre	est, shock, or heart	Approximate Interval				
/Medical Examiner		Immediate Cause (Final disease a. Atherosclerotic Cardiovascul	lar Disease				Between Onset and Death				
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Box 68760, death certificate be to attending physicid for use as the buri	흥	4 Pregnant at time of death 5			,	11.0.1.1.1	Day Todi				
Bo ne dea the a	Physician/Med	1 Yes 2 No 9 Unknown 9 Unknown									
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aw renas be	Completed				24a. Was a autops	sy prior to	autopsy findings available o completion of cause of				
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tal Recian: The	Be	25. Was case referred to medical examiner? Hospital: Input ient 2 ER/Out		of Death (Check onl	y one)						
Physical Circles	욘	1 Yes 2 No		Other Nursing I		Residence 6 🗹 Oth	er: Scene				
Division of Vital Records, tal or Attending Physician: The law requires after death. al Director: After this certificate has been sited in by the fineral director, page 2 should	Certification:	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. T			3d. Describe h	ow injury occurred					
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	틥	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, far	rm, street, factory, office b	building, etc. 28	or Town, St		Rural Route Number, City				
E G Di		4 Homicide	Manager and at the street	1							
	Medical	Check only 1 Certifying Physician: To the best of my knowledge, deat one) 2 Medical Examiner: On the basis of examination and/or in	vestigation, in my opinion	ate and place, and du , death occurred at th	e to tne cause ie time, date a	e(s) and manner as stand due to	ated. the cause(s)				
To wit	Me	29b. Signature and title of certifier	29c. Licens			29d. Date signed (M					
		() chala and	0.0.1	M.E.	j	January 13, 20					
	- }	30. Name and address of person who completed cause of death (Item 23a)	_								
		Laron Locke MD. Assistant Medical Examiner 900	W. Baltimore Street	t, Baltimore, MD	21223						
		31. Date filed (Month, Day, Year) 32. Registrar's Signature	1			····					
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ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20 Î Î Ouida Shone 19. January 6:45 a. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3644 Edelmar Terrace Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕅 F Months Days Hours April 25,1925 Texas **Director** 85 463-20-8848 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d, Inside City Limits Director Montgomery MD Silver Spring 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? and Mental Hygiene. is marked other than "natural", or items 23a or raumatic event, the Medical Examiner must be I Funeral 20906 United States 3644 Edelmar Terrace 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Transcriptionist Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George Edward Lisenby Belle Holland Mattie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. John Michael Shone / Son 9702 Wyndham Dr., Frederick, MD 21704 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 01/21/2011 Chesapeake Crematory Beltsville, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Rapp Funeral & Cremation Service 21. Sig ure of unetal per ice Licensee M00982 933 Gist Ave. Silver Spring, Maryland 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death
4 YEARS Immediate Cause (Final Physician, disease or condition END STAGE RENAL DISEASE Medical resulting in death) Due to (or as a consequence of): **Examiner** Secuentially list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury burial-trans that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Completed by Physician/Medical the use as 1 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No jo 5 Other (specify) Pregnant at time of death Month Day Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 signed by the a page 2 s certificate has funeral director, this (After 24 hours after death. Funeral Director: A filled in by

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 2 **X** No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🛛 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury X Natural 5 Pending work?
1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1XXCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

29c. License number

D19192

20902

29d. Date signed (Month, Day, Year,

January 20, 2011

State Registrar

completed

within 2 To the 1

Be

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Certificate:

Medical

only one

29b. Signature and title of certifier

JAN 2 I 2011

Barry Hecht M.D., 3941 Ferrara Dr., Wheaton, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Month **Physician** 05-200 A M Ethe1 Schmidt 201 Mary anuary /Medical 4b. City, Town, or Location.

Baltimore

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yee April 22, 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 19nes HOSPITO 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1922 1 □ M 2 🕶 F Maryland 214-14-9966 Yrs 88 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1√Yes 2 No Director MD Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21223 USA 3162 Wilkens Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ⅓No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify: White Š 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemkaer <u>Own Home</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Collins Schawellenberg Lillian Lawrence ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 652 Opel Rd., Glen Burnie, MD 21060 John L. Schmidt (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify Entombment Loudon Park Cemetery 1/22/11 Baltimore, Maryland 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Line 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 4 days Physician UVO SELSIS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the burial-trai Due to (or as a consequence of) the attending physician Box 68760. Physician/Medical IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Vear 5 Other (specify) 9 Unknown s been signed by should be detach that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Physician: The law requires Torillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Record Completed Kidney Stones 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 X No 2 NO Division of Vital 1 ☐ Yes 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 29a. Certifier 📆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number mindle chang, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Caton Ave. Baltimore. ling-Hs: Wana 900 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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11-00292 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Henry Yuk Kong-Tom State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) Physician/ Date of Deat Month **Medical Examiner** 0810 hrs Henry Yuk Kong Tom January 10, 2011 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Union Memorial 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Hours Director 02-25-1946 Country) Hawaii 64 1 X M 2___F 575-48-1203 Usual Residence of Deceden 10a State 10c. City, Town or Location 10d. Inside City Limits 10h County Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
injury or other traumatic event, the Medical Examiner must be notified at once. 1 X Yes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 327 Homeland Southway 21212 USA Ξ Funeral 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Asian 1 X Never Married 2 Married Armed Forces? _ Yes 2 X No White 4 Divorced If Yes, Give Year or Dates: 1 Yes 2 X No specify: Specify: <u>۾</u> 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Johns Hopkins University Press Executive Editor 12 5+ 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Hee Wo Tom Dorothy Dang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Honolulu, HI 96817 James Y.S. Tom - Brother 155 E. Beretania Street E 1009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Hilltop Service Corp. 01/18/2011 Towson, Maryland 4 Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 5305 Harford Road Leonard J. Ruck, Inc. lexandu Baltimore, MD 21214 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a, Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - transit Division of Vital Records, P.O. Box 68760, tall or Attending Physician: The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy 2 Fetal death Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 🗌 DOA Other Nursing Home 5 Residence 6 Other 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day,Year) 27 Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural hours after death. 1 Yes 2 No the f Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City Could not be 24 hours a determined 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 2 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 11, 2011 30. Name and address of person who completed cause of death (Item 23a)

10

Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Date filed (Month Day Year) 32/Registrar's Signature

31. Date filed (Month Day Year) 2011 32/ Registrar's Signature

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month DYTES 3:35 January Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** tomore g. Birthplace (State or Foreign 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 M 2 D F Days Min. Months Hours Yrs. Director Usual Residence of Decedent show 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10a State 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 Yes 2 No timor 10e. Street and Number 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 X Yes 2 ☐ No Specify. Specify 3 ☑ Widowed 4 ☐ Divorced American Year or Dates Dan 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print Caregiver) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) So 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signat e of Funeral Service Licensee ame and Addres . MI) 21216 HVENUE 23a. Part . Enter re disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shrick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) HOCK Hunting Medical Due to (or as a conse --- nce of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): ng physician and as the burial-transit resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? for Month Pregnant at time of death 2 No g Unknown 1 ☐ Yes ∠ 9 ☐ Unknown should be detached the P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has birector, page 2 s autopsy performed' death? 2 X No 2 🗌 No Yes Be 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital 2[®]内 No Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending 1 Yes 2 🗌 No ☐ Accident Investigation Director: / 3 Suicide 4 Homicide 6 Could not be within 24 hours after de
To the Funeral Directo
completed filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar DHMH 17 Rev 7/2009 (Check

29b. Signature and title of certifier

31. Date filed (Month, Day, Yo

N

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

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3 Acertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Joe Henry Vines Sr. 201 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Balhmore Hospi Baltimore 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Year) Days 1X M 2□ F Months Min Director 240-44-3284 76 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, the Medical Examinar must be multified at Funeral Director Gwynn Oak MD10e. Street and Number 10g. Citizen of What Country? 3716 Milford Avenue 21207 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: African-American þ Specify: 3 Wildowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) MIA 11th Bus Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Augusta Forbes Charles Vines ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Imporant: If item 27 is 3716 Milford Avenue, Gwynn Oak, MD 21207 Lillian A. Vines/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Veterans | 1-24-2011 Owings Mills, MD 22. Name and Address of Facility 9200 Liberty Road, Randallstown, MD21133 21. Signature of Funeral Service License /andas Wylie funeral Home P.A. of Baltimore County 2.4. Part Enter the disease, or complications that cause I the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each ine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myocard hours /Medical Due to (or as a consequence of): Examiner lated Cardi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 DUnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen: 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autopsy performed?

1 □ Yes 2 ☑ No this certificate Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ After this 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 9 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

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1 √Yes 2 No

Year

Baltimore, MD 21215

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 2 1 2011

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jan 17, 2011 Flossie Brown Vines 9:30A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Pikesville Baltimore 207 A Oaks Ave. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday, 8. Date of Birth (Month, Day, Yea **Funeral** 9. Birthplace (State or Foreign Hours 1 M 2XX F Months Days 77 Director 244-44-0750 Oct 18, Usual Residence of Decedent 28a-f shov 10a. State "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director NC. Burlington Alamance 1XX Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 27217 USA 2520 Hyde St. within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian the Medical Examiner Yes XX No ģ 1 Never Married 2xx Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Department Store Sales Clerk Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Della Farmer James Walter Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter Loretta White 207 A Oaks Ave., Pikesville, MD 21208 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ★ Burial 2 Cremation 3 ★ Removal from State Jan 20, 2011 Pine Will Cemetery Burlington, NC 4 Donation 5 Other (Specify) Sign of Fun ral Service 22. Name and Address of Facility Fink Funeral Home, P.A. Fink M01148 Greggr 426 Crain Hwy S., Clen Burnie, Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between ar heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death h sician/ Pulmonary disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine frany, leading to immedia cause. Enter Underlying Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and signed by the attending physician and dbe detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☒ No Month Pregnant at time of death Yes 1 ☐ Yes ∠ ¥ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by SECHRTHRITIB: DIABETES 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown ATRILL FIBRILLATION 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform**yey**? 1 \(\text{Yes} \(2 \) \(\text{No} \) 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Certificate: To 1 XXYes 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1XX Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 2 | Medical Examiner: On the basis of examination and/or investigation, acting opinion, seath cooling at the time, date and place, and due to the cause(s) and manner as stated.
3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) D0054653 JANUARY 18, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOLLY DAHLMAN, MD 2360 W JOPPA RD. LUTHERVILLE, MD 21093

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year 01:23 AM Walker Richard Lee 2011 January 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Agnes Hospital Baltimore N/A If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) Social Security Number 6. Sex Months Days Hours 1 ₹ M 2 □ F 219-50-6173 63 Aug. Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City. Town or Location 1 Yes 2 No Baltimore Halethorpe MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21227 5234 Dewitt Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2No Specify Specify: White 3 ☐ Widowed 4 🏋 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Electrical Services Electrician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Rohe Walker Eugene 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5628 Oakland Road, Halethorpe, MD 21227 Kimberly Petry / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. 01/20/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Thomas Gregor 22. Name and Address of Facility MacNabb Funeral Home, P.A. 301 Frederick Rd., Catonsville, MD 21228 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. days Immediate Cause (Final Bleeden disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 □Yes 2 □No 1 ☐Yes PANO 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → NO 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Matural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

P.O. Box 68760,

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tra is certificate has been signed by director, page 2 should be detact Division of Vital Records, this Director: After within 24 hours after death. To the Funeral Director: A

Physician

/Medical

Director

Funeral

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Completed

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Physician/Medical

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Medical Certification: To

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29a. Certifier (Check only

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be neatlisted at once.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

10 State

Registrar

29b. Signature and title of certifier

and manner stated.

29c. License number P25485

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

January 19 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Avenue Baltimore MO 21229 Shercha Caton

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Пау Year Victoria Wilson **Physician** Marsha рм 9:30 2011 11, January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Long Green Center If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Funeral Min. Months Days Hours 219-32-2517 1 □ M 2 🕏 F 72 MD Director 08/20/1938 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once. Parkville 1 ¥Yes 2 □ No Baltimore MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21234 1 Neptune Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【★No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify Completed by **3** Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Service Maid 1 Ó 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marian Johnson Milton Pinkney ျှ 19b Mailing Address (Street and Number of Rural Route Number City or Town, State Zip Code) 18 Montpelier St, Baltimore, MD 21218 ^{19a,} Informant's Name/Relationship (Type. Print) Marian Thompson / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place)
Final Journey Crem. Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/24/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21203 21. Signature of Funeral Service Licensee Dorota Marshall Mouslia Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Brain **Physician** Stem Dac /Medical Due to (or as a consequence of) Examiner tensive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be execute pertension Due to (of as a consequence of): Division of Vital Records, P.O. Box 68760 physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 Other (specify) 1 □Yes 2 No signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t lirector, page 2 sl autopsy performed 1 ☐Yes 2 ☐ No 2 NO 1 □ Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural after death.

I Director: Al
d in by the fu 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours aft e Funeral Di letely filled in 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hou To the Fune completely fi (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of perso who completed gause of death (Item 23a) (Type, Print) - as+ 03 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20b. perFH, G911, 1/21/2010, WS
State of Manyland / Department of Health and Mental Hygiene

			For State Registrar		State of Ma	aryianu	•	tificate of E		and Me		Reg. N		L 01175
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JANUARY Baltimore, N	Page 1 arment of He tant: If iter jury or oth		4 Donation	Cremation 3 5 Other (Specif		cem	etery, crem I Ridge	ition (Name of atory or other place Cenetery	Ĭ	1-25 ⁰ 2 1-25-20	10-	Pik	Location - City or	AD
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Division	or Atten after deat Director:	Certificate:	2 Accident 3 Suicide 4 Homicide	Investigation 6 Could not be determined			e, farm, stre		100 2 2		Location (S City or Tow			ral Route Number,
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-	Physicia Medic	al	Decedent's Name (First, Middle, Last) Nancy Waters A. Facility Name (if not institution, give street)	et and number)		4b. City. I	own, or Location		2. Date of De Month O I	ath Day	Year 2011	12	of Death
	Funeral Director		Union Memorial Hospital 5. Social Security Number 6. Sex	L	n yrs. last birthda 78 Yrs	y) If Under	timore Year If Under Days Hours	er 24 Hrs. Min.	8. Date of Bird (Month, Da 10–21–10	th y, Year)		irthplace (State ountry)	or Foreign
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960	rs after death iral", or items Examiner m	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced	. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	r in U.S. 1		nt of Hispanic O y Cuban, Mexica No Specif		fy Yes or No- ican, etc.)		14. Race - Am Black, Wh Specify: Afr		rican
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		15. Decedent's Educe (Specify only highest grade of Elementary/Seconday (0-12) 12th		(Gi	icedent's Usual ive kind of work i. DO NOT use anaker	done during mo	st of working	7		nd of Busines: estic	s Industry	
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Division	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page	al Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (street, factory,	office	2	8f. Location (\$ City or Tov			ural Route Nu	mber,
	the Hospi hin 24 hou the Funer apleted fill	Medical	29a. Certifier (Check 2 Medical Examiner only one) 3 Certifying Nurse P	On the basis of exar	mination and/or in	vestigation, in n ge, death occurr	ny opinion, death ed at the time, da	occurred at t te and place	he time, date a	and place e cause(s	, and due to the and manner a	e cause(s) and ras stated.	manner state
	5		29b. Signature and title of certifier		M.D.		License number				te signed (Mor		
	3		30. Name and address of person who com Walid Barb	iour, Un	iion M	emoria	l Hospiti	al, B	altimo		·	21218	
	Sta Registra	te ar	31. Date filed (Mooth, Day, Year)	32. Registra 's	Signature	1							

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#5perFH, G915,5/19/2011, WS
State of Maryland / Department of Health and Mental Hygiene | For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ January 19, 2014 WARREN 8:45P M MADELINE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson 7307 Yorktowne Drive 220-07-2204 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1 □ M 2 👿 F Months Days Hours 02*/*/20/7920 Mary Tand 20 04 90 Director Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location within 72 hours after death with the Maryland Director 1 Tes 2 No Maryland Baltimore Towson 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21204 7307 Yorktowne Drive USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Mamied 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) I Hygiene. the Accounting Girl Scouts of America traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit, Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even မ Frederick Nicholas Schindhelm Mary Hammen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7307 Yorktowne Drive Baltimore, Maryland 21204 Davle A Dabney DTR 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State Sacred Heart of Jesus 01/24/2011 Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) ature of Funeral Se 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, o complicati shock, or heart failure. List only one ca s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death)) Medical Due to (ø/ as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence or) physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Dav 5 Other (specify) Pregnant at time of death sate has been signed by the page 2 should be detached Unknown 9 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? autopsy performed 2 🗌 No certificate Yes 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospita Other: 2 XNO 1 Inpatient 2 ER/Outpatient 3 DOA |은 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 3 Suicide 4 Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 9M05 want 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EVANGELOS LIGNOS 7801 YORK 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 I 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Irene M. Wilson ам January 2011 11:00 Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 719 Maiden Choice Lane HR637 Catonsville Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 04/20/1928 Months Days Hours Min. Country) 1 🗆 M 2 🔀 F 215-24-0244 Director 82 PA Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Catonsville 1 Ves 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 719 Maiden Choice Lane HR637 United States 21228 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black, White, etc Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify. White Specify: 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Sullivan Marv Necker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon L. Lutzi (Daughter) 100 West 67th Street, Apt. 2SW, New York, NY 10023 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 01/20/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 21. Si nati re of Funeral Service License 22. Name and Address of Facility Hubbard Funeral Home, Inc. Þ 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ 4 E-ar disease or condition) Medical resulting in death) Due to (or as a consequence of) Examiner 4ears 28-Sequentially list conditions, if any, leading to immediate cause. Litter underlying Cause (Disease or iinjury Examiner Due to (or a a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director: nane 2 should be added. that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 🖫 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Gettiying Prystation: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1-20-2011 D38747 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO 21223 Suite 107 Bulto. T Bel 516 N. Rolling Rd

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

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		Funeral Director		5. Social Security N 218-26-	lumber	6. Sex	M 2□F			last birthdaj Yrs.) If Un Month	der 1 Year ns Days		nder 24 Hrs. Irs Min.	8. Date of Bi	rth ay 63	7)1	9. Bir Co	thplace (State or Forei
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	Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Na Mary E.											al Route Numb ingdon				p Code)
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g	Box 68760	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent		23c	. If yes, out			ancy al death 3	☐ Ectopi	ic pregnan	icv				23d. D	ate of de	livery
Edmund		e death the attorned for	ysicia	in the past 12 l 1 ☐ Yes 2 ☐ 9 ☐ Unknown	□ No		4 Preg	nant at			Other		,				М	lonth	Day Year
图	P.O.	requires that the de been signed by the should be detached		Part II. Other signif				- (underlyin	g cause gi	iven in F	Part I.	23e. Did	tobacc	o use con	tribute to	the cause of death?
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1	U			30. Name and addre	ess of person		ΛD pleted caus	se of de	ath (Item	1 23a) (Tvpe	, Print)	100	ב שנ	1-1	, Bel :	Jai	1001	3, .,	B, 2011
10				Christa) Fist	ier, V					Che	oper	ake	Drive	, Bel ,	hr,	MD	21	014
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 09:15 PM EONARD WALTON 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A JOHNS HOPKINS BAYVIEW BALTIMORE MEDICAL If Unde Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Days Hours Min. (Month, Day, Ye Maryland Director 1943 217-40-7662 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at. 10a. State 10d. Inside City Limits 10c. City. Town or Location rector 1 🗆 Yes 2 🖺 No Dundalk Baltimore MD ۵ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2826 Creston Road United States 21222 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 K No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. and Mental Hygiene. is marked other than "natural", or i 1 Never Married 2 Married þ 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Divorced 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 9 Years Techolly Line Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ၉ Pearl Gibson Alfred Walton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2826 Creston Road Dundalk, MD 21222 Mrs. Frances L. Walton(Wife) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1
Burial 2
Cremation 3
Removal from State Hilltop Service Corp. 1/18/2011 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22 Name and Address of Figure 1 Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Deeth Physician/ MYOCARDIAL INFARCT disease or condition Medical resulting in death) Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Litter Uniterlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph d for use as th IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending M 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) To the Hospital Medical 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

JANUARY 13th, 2011 29c. License number RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVE BALTIMORE, HD 21724 4940 EASTERN WANSOM MD

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Pathent-Rnown as Adela Zafran Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Division of Vital Records, P.O. Box 68760

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		For State Registrar			Marylan		epartment of F Certificate of L		,	giene Reg. No. 201	0118
nysicia Media		1. Decedent's Name		ZAFRAN					2. Date of Dea Month ANUA	Day Yea	3. Time of Death
_ ∈xamir	ner	4a. Facility Name (if	HOSD	give street and number	Baltin	nore		Location of Death	<i>M</i>	4c. County of D	
Funeral Director		5. Social Security Number 6. Sex 1 M 2 XF 93 Yrs. 6. Sex 1 M 1 M 2 XF 93 Yrs. 6. Sex 1 Months Days Hours Min. 1 M 2 XF 07/01									Birthplace (State or Foreign Country) POLAND
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uld be fil I Mental marked natic ev	10	BENJAM	IN	ERL	ICH			MIRIAM		SCHWA	RTZMAN
nd 2 sho ealth and m 27 is i ner traur			EGLEITE	o (Type, Print) R/DAUGHTER			ailing Address (Street a 509 WICKFI				Zip Code) 21209
Page 1 a nent of H unt: If ite iny or otl		20a. Method of Disp 1 X Burial 2 ☐ 4 ☐ Donation	Cremation 3	B ☐ Removal from State	ite C	emetery, c	sposition (Name of rematory or other place ZION CONG	9)		20c. Location - City	or Town, State ORE, MD
permit. Departn Imports any inju		21. Signature of Fun	neral Service Lic				22. Name and Addres	s of Facility SO	OL LEVIN	SON & BRO	S., INC.
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Physician/ _ Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):									Onset and Death
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or Atteno after death Director: / in by the i	Certificate:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	Investigat 6 Could no determine	t be 28e. Place of Ir	njury - At hor etc. (Specify)	ne, farm, s	M 1 ∐ Y	′es 2 □ No	28f. Location (Str City or Town,	eet and Number or F State)	Pural Route Number,
Hospital	<u>a</u>	(Check 2 L	_ Medical Exa	miner: On the basis of	examination	and/or inve	n occured at the time, o	 death occurred at 	the time, date and	d place, and due to the	e cause(s) and manner stated
To the To the Comple		only one) 3 [29b. Signature and til	☐ Certifying No.	urse Practioner: To th	e best of my	knowledge	e, death occurred at the	time, date and place	e, and due to the	cause(s) and manner and the cause(s) and manner and decided (More	as stated.
		30. Name and address	ss of person who	o completed cause of	death (Item :	23a) (Type	PES-	- 000		anuary	192011
		SSICA T. Date filed (Month,	Rearc	on DD	SIN	ait	tospital	of Ba	th mov	e	
State Registra	_	Date filed (MOHER,	JAN 2	1 20 1 32. Regis	rar's Signatu	A.	park				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene StateRegistrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month 0704 AM ULIUS A. ANTONE 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SPRING HOSPITA CROSS UBR MONTGOMERY Social Security Number Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) 1 **№** M 2 🗆 F Director Usual Residence of Decedent 28a-f show 10a. State 10b. County other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Nes 2 No WD MONTGOMERY 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 1190 10000 BRUNSWICK US A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. UNK 1 Yes 2 No Specify: Completed 3 ₩ Widowed 4 □ Divorced WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) スロダ NWN $\mathcal{N}\mathcal{N}\mathcal{N}$ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ NUI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 SHERRY DAVIS CURRDIAN NW Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of h Important: If ite any injury or ot once. Date Signature of Euneral Service Licensee ROHAId S Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Enter the dise ve, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, r heart failure. List only one cause on each line. Immediate Cause Final Onset and Death Physician/ disease or condition resulting in death) ACUTE MYOCARDIAL INFARCTION Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to in modato cause. Enter Underlying Cause (Disease or linjury Examine Dusi to (or as a consequence or use as the burial-transi that initiated events Due to (or as a consequence of): attending physician Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day signed by the a d be detached for 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of this certificate has ral director, page 2 autopsy death? Yes 2 N 1 ☐ Yes 2 ☐ No Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certific Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No ပ Other: 1 🗀 Inpatient 2 🔯 ER/Outpatient 3 🗔 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident work? 1 ☐ Yes 2 ☐ No Investigation Could not be by the 1 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F 3 Certifying Nurse Practice 1: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of Stiffer 29d. Date signed (Month, Day, Year) D09834 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

BARRY

Date filed (Month)

ROSENBAUM

MD

Registrar's Signature

3720 FARRAGUT AVE KENSINGTON MD 20895

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 18:55 PM hristina Januaru 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec 25, Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Hours Maryland 217-26-4102 Director 81 Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits oms 23a or 28a-f sho must be notified at Director YYes 2 No Md. Baltimore City 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral be filed within 72 hours after death with 2819 Hudson Street 21224 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates o, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White "natural" 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry ed other than " event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) 7th <u>Sewer</u> <u>Graflin Bag Company</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည Joseph Schultz Clara Piasecki 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other traconce. Linda Arthur / Daughter 2819 Hudson Street Baltimore, Maryland21224 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State January 1 Burial 2 Cremation 3 Removal from State 24,2011 Baltimore, Maryland Bayview Crematory: 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kaczorowski Funeral Home, PA 1201 Dundalk Avenue Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Gastrointestina Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy ☐ Pregnant at time of death 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year this certificate has been signed by the all director, page 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 M Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No Division of Vital To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 Matural
2 D Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State, e Funeral Medical 29a. Certifier 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Baltimore Kara Loubser 4940 Eastern Avenue 31. Date filed (Month, Day, Year)
JAN 2 4 2011 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Bah Physician/ JAnuar Year Mohamad 11:30AM Medical Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner orner Prince Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State **Funeral** 1 XM 2 □ F Months Hours Min Director eone item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland City, Town or Location Completed by Funeral Director 10d. Inside City Limits 1 Nes 2 No aure 10f. Zip Code 10g. Citizen of What Country? 20707 54 orner 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Never Married 2 Married Black, White, etc Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates Specify: Specify: Blace 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. PO NQT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) ρ heik ah 19a. Informant's Name/Relationship (Typ Department of Health a Important: If item 27 is any injury or other trains 4107 orner 20a. Method of Disposition 20b. Place of Disposition (Name of 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune a Service Licensee CC0278 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) recta ancer Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Pregnant at time of death Month 5 Other (specify) Day Year 2 🗆 No ا 24 hours after death. e **Funeral Director.** After this certificate has been signed by the se **Funeral Director.** After this certificate 9 Unknown g | Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed! Yes 2 No 1 🗌 Yes Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 🗹 No Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No Accident
Suicid Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number MSKYKPAMIEM.D DO057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD. 21209 AV. S-203, S. Rajapakse, M.D. 2835 SmiTh 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

11-00444 John Bailey, Sr. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

John Bailey, Sr	State of Maryland / Department of Certificate of Registrar		Reg. No.	01185					
Physician/ Medical Examine			Date of Death Month Day Year January 15, 2011	3. Time of Death 2305 hrs					
	4a. Facility Name (if not institution, give street and number) 330 Central Avenue	4b. City, Town, or Location of Death Hagerstown		th					
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 5. 4 9 - 6.6 - 2.4.2.2 12 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Min	-						
Maryland 28a-f show any 1 at once.	Usual Residence of Decedent 10a. State			10d. Inside City Limits 1 Yes 2 No					
the Maryland is or 28a-f sh stiffed at once	10e. Street and Number 330 Central Ave	10f. Zip Code 21740	10g. Citizen of What Col	untry?					
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland not of Health and Mental Hygiene. Ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other transmitic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	or Dates:	as Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto Yes 2 No specify: nt's Usual Occupation (Give kind of v	Rican, etc.) White, etc. Specify: Wh:						
5-0036 ed within 72 hour tygiene. other than "natt	Elementary/Secondary (0-12) College (1-4 or 5+) N / A N /	nost of working life. DO NOT use reti	ired) N/A	,					
21215-0036 ould be filed within 7 Mental Hygiene, marked other than ic event, the Medica To Be Comple	17. Father's Name (First, Middle, Last) Alvin Nathan Bailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailin	Lois E	e (First, Middle, Maiden Surname) Isie Harring Rural Route Number, City or Town, State						
w, MD 21 and 2 should leath and Me ten 27 is ma traumatic ev	Shawn Bailey /Son 1255	Jefferson Bl	vd Hagerstown,	MD 21742					
Baltimore, N permit. Pages I and Department of Health Important: If item injury or other trau	1 Burial 2 Termation 3 Removal from State Final Journal of Company of the Property:	ourney 1/2	Date 20c. Location - City o 22/11 Woodbine	, MD					
Physician /Medical xaminer	23a. Plart I. Enter the disease, or complications that caused the death. Do not enter the disease or condition. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause		rrespiratory arrest, shock, or heart	Approximate Interval Between Onset and Death					
50, to be executed ysician and bunal - transit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.	per me g913 3-9-1	1						
	X UNPENDED X AMENDED 23a, 27, 20a-1 #6perFH, G911, 1/24/1	.1,WS	23d. Date of deliver	v					
Box e death the atte	23b. Was decedent pregnant in the past 12 months?	etal death 3 Ectopic pregna ther (Specify)		Day Year					
	Part II. Other significant conditions contributing to death but not resulting in the	ınderlying cause given in Part I.	23e. Did tobacco use contribute to 1 Yes 2 No 3 Pro						
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach ertification: To Be Completed by Pl	25. Was case referred to medical	26.Place of Death (Check of	autopsy prior to death? 1 ✓ Yes 2 No 1 ✓ Yes	utopsy findings available completion of cause of					
of Vital I Jing Physician: After this certifi funeral director, on: To Be (examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 27. Manner of Death 28a Date of Injury 28b Time of	3 DOA Other Nursin	g Home 5 Residence 6 🗸 Othe	r; Scene					
Sion o	27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident Investigation Pending		28d. Describe how injury occurred unknown						
	Suicide Sui								
To the Hos within 24 hr To the Fun completely	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigal and manner stated.								
E & E &	29b. Signature and title of certifier Theoglose M. Kirst Th. we D	29c, License number O.C.M.E. COME	29d. Date signed (Mo January 16, 201						
٧	30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner	900 W. Baltimore Street, Ba	altimore, MD 21223						
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ BROOKS SAVANNAH 7:20 PM Month ZOII Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NORTH HAMPTON NUNSING Home FREDERICK FREDERICK 6. Sex 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 1 🗆 M 2 🗹 F (Month, Day, Year)

MAR 17, 191 Hours Min. Director 220-18-073 ms. Usual Residence of Deceden ral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho. 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD. FREDERICK FREDERICK 1 Yes 2 No 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? Funeral 201 MADISON ST 21701 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ģ 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 ☐ Yes 2 No If Yes, Give Year or Dates. 1 ☐ Yes 2 Z No Specify: 3 ☑ Widowed 4 ☐ Divorced Completed Specify: BLACK event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE FAMILY DOMESTIC /UNK) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည CLIFTON BELL TAMES ROSA WILLIAMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHERYL JOHNSON 18319 MISTY ACRES DR. HAGERSTOWN MD GRBAU 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it Burial 2 Cremation 3 Removal from State ST. DAYL CH. CGM 4 ☐ Donation 5 ☐ Other (Specify) JAN 20,2011 GREENFIELD, MD. 21. Signature of Funeral Service License 22. Name and Address of Facility CARY L. ROLUNS FON HOME grany J. Ko SOUTH ST PREDERICK MD 21701 WEST 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Physician/ on gotive Onset and Death eurt disease or condition Medical resulting in death) Due to (or as a nsequence of) Examiner MYOC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Day 5 Other (specify) Month been signed by the should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law performed? Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ဂ္ 1 🗆 Yes Other: After this 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 Yes 2 No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in this opinion, seath occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11 Grys

Registrar

DHMH 17 Rev 7/2009

State

FREDERICK MD 21701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUSTIN PCARE MD 300 WEST 974 ST

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Bohonas January Junaita Mae 201T 3:30am Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3998 Gamber Road Finksburg Carroll 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) WV **Funeral** Age (In vrs. last birthday) 8. Date of Birth 1 🗆 M 2 ⋤ Days Hours Jan 28, Director 219-22-5537 84 Ĩ926 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f s notified MD Carroll 1 Yes 21 No Finksburg 9 10e. Street and Number 10f. Zip Code must be 10g. Citizen of What Country? 23a Funeral 3998 Gamber Road 21048 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Examiner 14. Race - American Indian Armed Forces 1 L Yes 2 No Black, White, etc. ō þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: "natural" Completed White Specify: Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene, Elementary/Seconday (0-12) College (1-4 or 5+) the 12 Machine Operator Cup Factory other traumatic event, Be permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 Is marked any injury or *** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည William Henry McCartney Flora Mae Allman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Teresa Ann Fringer (Daughter) 3998 Gamber Road, Finksburg, MD 21048 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Evergreen Mem. Gardens 1/28/2011 4 ☐ Donation 5 ☐ Other (Specify) Finksburg, MD Signature of Funeral Service Licenses 22. Name and Address of Facility ^{acility} HAIGHT FUNERAL HOME & CHAPEL, PA Sykesville, MD 21784 PO Box 195 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final ongestative Onset and Death Physician, disease or condition Medical resulting in death) Due to (or consequence of) **Examiner** AMICIL Fihr Sequentially list conditions, Examine if any, leaving to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of sician and burial-transit Due to (or as a consequence of) resulting in death) Last physician Physician/Medical that the death certificate be Box 68760 the attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Month Year signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Records, or Attending Physician: The law requires Completed been si should I 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 ☐ Yes 2 ☐ No **Division of Vital** funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 20 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending iniury within 24 hours after death. To the Funeral Director: A Accident Investigation completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Medical 29a. Certifier 1/2 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one 29b, Signature and title of certific 29c. License number M.D DUOFTUF rson who comple filed (Month, Day, Year) State 32. Registrar's Signature 24 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Dogtwick 11:41 Medical 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Jorthuses Hospital Randallstown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Davs | Hours | Min. | (Month, Day, Year, 5. Social Security Number Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🗆 M 2 😾 F 213-28-9766 Director Country 78 1932 MD Feh Usual Residence of Decedent 10b. County N/A shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ms 23a or 28a-f sho must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4219 Bonner Road 21216 USA ral", or items? 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Completed by 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 2 😿 No If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 XWidowed 4 Divorced Specify: Black other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) Bon Secours College (1-4 or 5+) <u>12th</u> Instrument Tech Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Unknown Dora Coleman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doralynn Boatwright/Daught| 4219 Bonner Rd. Baltimore, MD 21216 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ō permit. Page Department Important: If any injury or 2/1/11 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) Garison Forest VA Signature of Funeral Service Licensee 22. Name and Address of Facility Beverly D. Cromartie F/S 2700 Edmondson Ave-Balto., MD rosucce Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician. Onset and Death disease or condition Athenosclerc Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury うしゅしゃし that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day signed by the a d be detached f 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed should 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s s after death.

Director: After this certificate has autopsy performed? Yes 2 No 1 Tyes 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) examiner? မ 1 Tes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident 1 🗌 Yes Investigation 2 🗌 No Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H60556414 2011 21, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

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32. Registrar Signature

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Leavinters A. Yorked

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 0:20 AM 4a. Facility Name (if not institution, give street **Examiner** 4c. County of Death Funeral 7. Age (In yrs. last birthday) If Under 24 Hrs. Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign C (Month, Day, Director Usual Residence of Decedent 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f s must be notified Itimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian, Armed Forces?

1 Yes 2 No Never Married 2 Married Completed by ò Black White, etc. If Yes, Give Year or Dates. 1 Yes 2 No "natural", Specify: 3 Widowed 4 Divorced Specify: permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Indust College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 3 Removal from State Donation 5 Other Spec Signature of Funeral Service acility 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dyng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) ROSTAT Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated eventials) Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Ph) IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached Unknown Unknown らせららから Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of perforn death? 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Division of Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work?
1 \sum Yes 2 \sum No Natural injury Accident 24 hours after death Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check To the within 2 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License number 30. Name and Addre erson who completed cause of death (Item 23a) (Type, Print) 7300 DUCKNEY Day, Year State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Betty Barlly January 20 T Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Vantage House Columbia Howard 5. Social Security Number Funeral 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Belgium 8. Date of Birth 1 M 2 X F Months Days Hours Min. Director 214-30-5903 0971971925 85 Usual Residence of Decedent items 23a or 28a-f show ner must be notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Howard 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5400 Vantage Point Road 21044 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🕱 No ö þ 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 "natural" Completed 3 XXWidowed 4 □ Divorced If Yes, Give 1 Yes 2 No Specify: Specify: Year or Dates White other traumatic event, the Medical 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) and Mental His marked of 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve Jacob Saks Rosa de Haan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Musser (Daughter) 5421 Wild Turkey Lane Columbia, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Atlantic Crematory 1-22-2011 Glen Burnie, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, MD 21045 23a. Part 1. Enter the disease, decemblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner VERTICULITIS Sequentially list conditions, if any, leading to humediate cause. Enter Underlying Cause (Disease or injury that initiated events) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Dav Year After this certificate has been signed by the a funeral director, page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 2 M 1 Tes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 🗹 No မ Other: 1 🗌 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funeral Director: completed filled in by the Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one Certifying Nurse Practioner: To the best of my knowledge, de occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier License number 29d. Date signed (Month, Day, Year) JAN 28-2011

State Registrar

DHMH 17 Rev 7/2009

Columbia, MD 21044

10840 Little Patuxent Pkwy.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kenneth Geh. M.D.

31. Date filed (Month, Day, Year)

JAN 24 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item I per doc g911 1-26-11 yt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Helen Patricia Bopp 2. Date of Death 3. Time of Death Day **Physician** 11:30P M HELEN 18, January 2011 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore St. Joseph's Nursing Home Catonsville 8. Date of Birth (Month, Day, Year May 24, 1 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Hours Min. 1 □ M 2 🛛 F Yrs. 91 1919 Maryland Director 215-05-5034 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r 28a-f show notified at 1 ☐Yes 2 X No Director MD Ellicott City Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or USA 21042 10152 Hobsons Choice Lane Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☑ No 3altimore, Maryland 21215-0036 Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) event, the Medical (Give kind of work done during most of working life. DO NOT use retired) of the and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) C & P Telephone Company 12 Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cora Matilda Coggins Edward Adam Bopp ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a 10152 Hobsons Choice Lane; Ellicott City, MD 21042 John Kellermann-Brother-in-Law other t 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of Important: If it any injury or conce. to 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cem. Baltimore, Maryland 1/25/2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke 21. Signature of Funeral Service Licenses M01050 Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** KNEummdisease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Division or Vital Records, P.O. Box 68760, physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending p as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Wyn has te 2 s autopsy Abland Anti por eugon performed 2 100 2 No 1 ☐ Yes certificate To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Funeral 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) within 24 h and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30 Name and address of gerson who completed cause of death (Item 23a) (Type, Print) 22 (by 4 100 Color. 1/4 NDZ. 120 OKALINE 400 Tolle

DHMH 17 Rev 1/2001

State Registrar filed (Month, Day, Year) AN 2 4 2011 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2011 John Baka Richard January 8:20 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Hospice Casey House Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month. Dav. 9. Birthplace (State or Foreign Country) New Jersey 5. Social Security Number . Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Days Hours Min (Month, Day,)
December 9 Months 71 Yrs. Director 150-30-7324 1939 Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 🗆 Yes 2 💢 No North Potomac Maryland Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 14962 Dufief Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 9 ò 1 Never Married 2 X Married 1 Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White "natural" Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. sant: If item 27 is marked other tha ury or other traumatic event, the N Electrical Engineer Telecommunications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Anthony Baka Helen Konvak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eardie E. Baka / Wife 14962 Dufief Drive, North Potomac, MD 20878 Date 21, 20a Method of Disposition 20b. Place of Disposition (Name of Place of Disposition (Name of cemetery, crematory or other place) Inc January 20c. Location - City or Town, State Department of H Important: If ite any injury or ot ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State Montgomery Crematorium, 4 ☐ Donation 5 ☐ Other (Specify) **2**011 Bethesda, MD Robert A. Pumphrey Funeral Home / Rockville, Inc. 300 West Montgomery Avenue, Rockville, MD 20850 21. Signature of Funeral Service Licensee M01596 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Parkinson's Disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached? 1 □ Yes 2 L 9 □ Unknown 9 \ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Autonomic dysfunction 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an Dementia performed?

1 Yes 2 X No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗓 No ᅀ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred injury X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check .Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 3 📈 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title 29c. License number 29d. Date signed (Month. Day, Year) R143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20855 Debrah Miller, CRNP 6001 Muncaster Mill Road, Rockville, Maryland

Registrar

State

31. Date filed (Month, Day, Year)

JAN 24 2011

DHMH 17 Rev 7/2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Herbert Emerson Counihan 11:30AM January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** George's 4307 Delmar Avenue Temple Hills Prince Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** New York 1 XM 2 □ F Days Nov. 1 Hours Min. 262-34-5330 83 **Director** Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Prince George Temple Hills 1 Yes X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4307 Delmar Avenue Funeral 20748 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black White etc. \$ 1 ☐ Never Married 2 🂢 Married Maryland 21215-0036 1 Yes 2 XNo Specify. Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry
U.S.Government: (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) e 1 and 2 should be filed within 72 t of Health and Mental Hygiene.
If item 27 is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) U.S.Air Force M<u>anagement</u> Anaylist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Herbert Counihan Virgina Donovan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20748 Agnes E. Counihan/Wife 4307 Delmar Avenue, Temple Hills, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite ò 1 Burial 2 X Cremation 3 Removal from State Hanover, Maryland 1-24-11 ArdentCremation injury (4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Marzullo Funeral Chapel, P. A 6009 Harford Road, Baltimore, Maryland21214 michael 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph sician/ prinsma disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 the as nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s performed? Yes 2 No certificate 1 Yes Division of Vital To the Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death. Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 1 Natural 28b. Time of Certificate: 28c. Injury at 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ess of person who completed cause of death (Item 23a) (Type, Print) 2 Drive G-06 CLINTON MD207.85 10403 MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** A^{M} 2011 9:30 January William Joseph Christopher III /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 9 Paula Place; Apt 1C 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 27, 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days ^{Year)}947 Months Hours Mary Land 1⊠M 2□F 63 220-50-3150 Director Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location 10a State of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, Ite Medical Examinar must be notified at 1 ☐Yes 2 X No Director Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21237 9 Paula Place; Apt 1C Funeral 1 and 2 should be filed within 72 hours after death v Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ★ Yes 2 ☐ If Yes, Give Year or Dates: 2□No 1966-1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No white Specify: <u>م</u> 3 Widowed 4 X Divorced 1969 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) janitorial supervisor 12 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) Be (unk ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 413 Bowleys Quarters Rd; Baltimore, MD 21220 Department of Health Important: If item 27 any Injury or other troonce. Bernard Kehl - friend 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 Other (Specify)in state 21. Signature of Fureral Service Licensee
Ronald S. Wade, 22. Name and Address of Facility State Anatomy Board Director 21201 655 W. Baltimore St; Baltimore, MD Approximate Interval Between Onset and Death Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician same /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Pres 2 No 3 Probably 4 Unknown cate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 No 2 No 1 Yes 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury e Hospital or Attending Pt 24 hours after death. e Funeral Director: After the letely filled in by the funeral 27. Manne of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar he Alameda

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11-00403

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

ames Thomas	Clei					giene	201	01106			
Physici	an/	Registrar 1. Decedent's Name (First, Middle,Last)	- Certificate (or Death		Reg 2. Date of Death	g. No. — — I	3. Time of Death			
ledical Exami		James Thomas Clemons		T		Month January 14		0807 hrs			
		Facility Name (if not institution, give street and number) N Summit Avenue		4b. City, Town, or Loc Gaithersburg	cation of Death		4c. County of Dea Montgomery				
Funeral			n yrs. last birthday)	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	-	1 0 2 0 Fore				
Director		431-44-2675 1 M 2 F	Oct 17,	1929	ountry) Arkansas						
any		Usual Residence of Decedent 10a. State 10b. County 10c	c. City, Town or Loc	ation				10d. Inside City Limits			
faryland 28a-f show	1 0	MD Montgomery		1 Yes 2 X No							
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. unt: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 415 Russell Avenue #1014	venue #1014 10f. Zip Code 20816			100	g. Citizen of What Co USA	untry?			
th with cens 23	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?		Vas Decedent of Hispar Yes, specify Cuban, M			14. Race - Ame White, etc.	erican Indian, Black,			
fter dea		1 Yes 2 X 3 X Widowed 4 Divorced If Yes, Give Yeer	No 1	Yes 2X No s	specify:		Specify: Whi	white			
nours a	ed by	15. Decedent's Education (Specify only highest grade comple	ited) 16a. Decede	ent's Usual Occupation most of working life. DO			16b. Kind of Business	s/Industry			
136 hin 72 h e. than "r	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		Lster/profe			educatio	on			
215-0036 be filed within 72 tral Hygiene. rked other than '	E O	17. Father's Name (First, Middle, Last)				First, Middle, Ma	aiden Surname)				
21215 Id be file Mental H narked c	Be	Russell Clemons				0'Fall					
9, MD 21215-003 and 2 should be filed within tealth and Mental Hygiene. Item 27 is marked other the traumatic event, the Medi	٩	19a. Informant's Name/Relationship (Type, Print) James Thomas Clemons Jr -		ng Address (Street ar 70 E. Laure				te, Zip Code) n, OH 43452			
re, MC 1 and 2 sl f Health ar f item 27 er trauma		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State		osition (Name of cemete	ery,	Date	20c. Location - City of	or Town, State			
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		4 X Donation 5 Other Specify:									
Baltimore permit. Pages 1 Department of H Important: If is		21. Signature of Funeral Service Licensee		Name and Address of 555 W. Balt			•	21201			
Physician		23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.						Approximate Interval Between Onset and			
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence)	ence of):					Death			
		Sequentially list conditions, b									
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	ance of):								
cuted and transit		events resulting in death) Last Due to (or as a conseque d.									
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Box 68760, i death certificate be the attending physical for use as the burned for use a	Physician/Me	past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown	o of death	Other (Specify)				,			
P.O. B ss that the de gned by the	by Ph	Part II. Other significant conditions contributing to death but	t not resulting in the	underlying cause giver	n in Part I.		acco use contribute to				
rds, P.C requires that been signed hould be deta						1 Yes		obably 4 Unknown utopsy findings available			
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tal Rection: The certificate ector, page	BeC	25. Was case referred to medical examiner?			Death (Check or	nly one)					
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Division of Vital Records, P.O. Box 68760, 24 hours after death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and retail Director: After this certificate has been signed by the attending physician and retail filled in by the funeral director, page 2 should be detached for use as the burial - transition of the pure of	ation:	27. Manner of Death 1 Natural 5 Pending	28b. Time of 0752 hrs				w injury occurred ruck by train				
Divis	3 Suicide 6 Could not be determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
Di To the Hospital within 24 hours: To the Funeral completely filled											
F S S	Medi	and manner stated. 29b. Signature and title of certifier		29c. License nu	umber	- 1	29d. Date signed (Me	onth, Day, Year)			
		WIN		O.C.M.E	Ξ.		January 15, 201	1			
		 Name and address of person who completed cause of death Donna M. Vincenti, MD Assistant Medical B) W. Baltimore St	reet, Baltimo	ore, MD 212	23				
St		31. Date filed (Month, Day Year) 32. Registrar's S	ignature facult								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2019 January Ronald David Camp 3:25 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Clinton Nursing Home Clinton Prince Georges 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 № M 2 🗆 F Days Hours Min. Dec 23 ^{Year} 950 Director Washington DC 578-68-7571 60 Usual Residence of Decedent 10a. State the Maryland 10c. City, Town or Location Director 10d. Inside City Limits must be notified 28a-f MD Prince Georges Clinton 1 Yes 2 No 10e. Street and Number 'n 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 9211 Stuart Lane 20735 Page 1 and 2 should be filed within 72 hours after death with USA ral", or items 2 Examiner mus 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc Completed by 1969 1 🛮 Never Married 2 🗆 Married Baltimore, Maryland 21215-0036 black If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: "natural", 1971 3 - Widowed 4 - Divorced event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. 12 car salesman automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and coof Health and tem 27 is marke. ဂ Raymond D. Camp Mary Alice Gray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2502 14th St NE; Washington, DC 20018 Dianne M. Camp - sister 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest a heart failure. List only one cause on each line. 23a Part Approximate Interval Between Onset and Death Immediate Cause (Final disease or conditio Physician, SR Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami burial-transit and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Unknown Month Day Year pec the P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law page 2 s has autopsy this certificate Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tyes ျှ 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpa 5 Residence 6 Other (Specify) funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 No Accident Investigation 6 Could not be M 1 Tyes Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar Smi

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 31 per dyr g911 1-24-11 yt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month nomasina AM :56 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner lemple rince Georges allaway If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Age (In vrs. last birthday) Funeral 1 🗆 M 2 🔀 F Months Days Hours Min. (Month, Day, Year) -4260 September 1 Yrs. Director Usual Residence of Decedent 28a-f shov 10b. County filed within 72 hours after death with the Maryland Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No mole Maryland Georges 5 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral Wa 0 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 No Specify Completed 3 Widowed 4 Divorced Specify: 1ac the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M any injury or other traumatic event, the M ones. Elementary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Farland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary had vin empleHi llaway 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State Brent wood Maryland Cemetery 4 ☐ Donation 5 ☐ Other (Specify) incoln 21. Signature of Funeral Service Licensee 22. Name and Address of Facility and mo Service 2605 S. Shirlington Read Artingba Ve 12206 Funeral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Medica Examine Due to (or as a con equence of Sequentially list conditions, Examiner cause (Disease or iinjury nce of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Pregnant at time of death Day Year 1 Yes 22 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: ျှ 2 🕅 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 2 🗌 No М Accident 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number Nace meny D0009162 1-24-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nazem 6196 Oxon Hill Rd = 200 Oxon Hill, md. 20795 31. Date filed (Month, Day, Year) 32. Fegistrar's Signature State 4 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State State Certificate of Death Reg. No. 2												01100	
			1. Decedent's Name (First, Middle, Last) 2. Date of Death										
	Physicia			S. Coni	ts				January		$1^{ m Year}$	3. Time of Death 11:45 A M	
	Medic Examin		4a. Facility Name (if not institution,		4b. City, Town, or	Location of Death		4c. County	of Death				
	u.xairiii		Gilchrist Cen	ter			Towson			Balti			
	Funeral		5. Social Security Number	5. Sex 1	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt Aug. 31		9. Birth	blace (State or Foreign	
	Director		057-26-4072 Usual Residence of Decedent	XX	81	115.			Aug. Ji	, 1727		310000	
7	show at	0	10a. State 10b. County		10c. Cit	y, Town or Loc	ation				1	0d. Inside City Limits	
	Maryi 28a-f otified	Director	MD Balti	more	No	ottingh						1 ☐ Yes 2XX No	
4	a or a		10e. Street and Number				10f. Zip Code	,		10g. Citizen of V	Vhat Cour	ntry?	
4	ms 23	Funeral	4239 Penn Ave.	40 Was Dass	edent Ever in U.S	E 12 V	21230 Vas Decedent of His		ocify Ves or No-	USA 14 Page	- Americ	can Indian,	
ဥ	1 and 2 should be filed within 72 hours after death with the Maryland. Health and Mental Hygiene. If Health and Mental Hygiene. It Health and Mental Hygiene. To its marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ρ	11. Marital Status 1 Never Mamed 2 XXMarrie	Armed Fo	orces?	H	Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)		k, White,		
3	ours a atural cal Ex	Completed	3 Widowed 4 Divorced	Year or D	ates.		ent's Usual Occupa			16b. Kind of Bu	siness Inc	dustry	
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212	withir giene er tha , the		6	College (Ov	mer			Restaur	ant		
Maryland 21215-0036	ntal Hy red oth	To Be	17. Father's Name (First, Middle, La Spiros Con					18. Mother's Nam					
2	ould by Men Men Men Men Men Men Men Men Men Men	İ	19a, Informant's Name/Relationshi			19b. Mailin	g Address (Street a		al Route Number	r, City or Town, S	tate, Zip (Code)	
E S	d 2 sh alth ar n 27 is er trau		Helen Conits				Penn Ave						
Baltimore,	Fage 1 an ment of He ant: If iten ury or oth		20a. Method of Disposition 1 XX Burial 2 □ Cremation 4 □ Dornation 5 □ Other (Sc		State	Place of Disponentery, crem Demet	ore,						
Baltı	permit. Page 1 Department of I Important: If it any injury or or once.		21. Signalize of Funeral Socice Lie	censee		9	Name and Addres Belai	s of Facility Scl r Rd, No	imunek ttingham	Funeral n, MD 2	Home 1236	e	
		Н	23a. Part 1. Enter the disease, or o shock, or heart failure. List on	complications that	caused the deat	th. Do not ente	r the mode of dying	g, such as cardiac	or respiratory arr	rest,		Approximate Interval Between	
P	hysician	01	Immediate Cause (Final disease or condition	Po	merc	eatic	Cane	er				Onset and Death	
	Medical Examiner		resulting in death)	Due to	(or as a conseq	uence of):							
7	p. is	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	(or as a conseq	uence of):							
bı §	ate be executed physician and the burial-transit	Examine	that initiated events resulting in death) Last C. Due to (or as a consequence of):										
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Box	requires that the death certifics been signed by the attending p should be detached for use as t	Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes	1 🔲 Live	Birth 2 Feta gnant at time of	al death 3	Ectopic pregnanc Other (specify)		23d. Date of delivery Month Day Year		US		
O. :	ned by detac	y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								se contribute to the cause of death?		
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ecor	S 85 S	omplet	Diabetes	melle	+05			7 0		osy rmed?	Were auto prior to co death? 1 ☐ Yes	psy findings available ompletion of cause of	
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Z Z	nysicii lis cer direc	To B	examiner? 1 Yes 2 XNo	Hospital: 1 □	Inpatient 2	ER/Outpatier	othe	er: 4 Nursing H	ome 5 Resid	dence 6 Othe	er (Specif)	input-ent	
n of	aing ri h. After th funeral		27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident Investig		e of injury oth, Day, Year)	28b. Time of injury	work'	rat ? Yes 2 □ No	28d. Describe h	ow injury occurr	ed		
Division of Vital Records,	to the hospital of variancing mysician: the lawithin 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page.	Certificate:	3 Suicide 6 Could n 4 Homicide determin	ot be 28e. Place	e of Injury - At he ling, etc. (Specif	ome, farm, stre y)	eet, factory, office		28f. Location (S City or Tow	Street and Numbern, State)	er or Rura	I Route Number,	
	Hospital 24 hours Funeral eted filled	Medical	(Check 2 Medical Fx	aminer: On the ha	isis of examination	n and/or invest	occured at the time, tigation, in my opinio death occurred at the	n, death occurred a	it the time, date a	ind place, and du	e to the ca	luse(s) and manner stated.	
4	Io the within To the сотры	Σ	only one) 3 Certifying 29b. Signature and title of certifier	radioner.	TO the Dest Of III	, Anomeage, C	29c. License			29d. Date signed	d (Month,	Day, Year)	
)		· Cofr.	carp			P12	5808		1-2	- 20	2[]	
	20		30. Name and address of person w	ho completed cau	ise of death (Item			Lew;	5 Vill.	1-2 e, MC	14.	(Ry 1204	
	Sta Registra		31. Date filed (Month, Day, Year) JAN 2 4 2011	32.1	Registrar's Signa								

DHMH 17 Rev 7/2009

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** ENda 13 2011 6:55 Januari /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Min. Days 1 □ M 2 🖫 F 212-44-5306 Yrs 67 Director 10-4-1943 MD Usual Residence of Decedent death with the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at ¶ Yes 2 □ No **Funeral Director** MD na Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip-Code 23a or 2 Apt USA Lanvale 21213 1300 E. Street 608 or items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of the file of Health and Mental Hygiene.
Int. If item 27 is marked other than "natural", or ite 1 Never Married 2 Married Specify: Black 1 Yes 2 No If Yes, Give Year or Dates: Specify ş 3 Widowed W Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) unk (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roosevelt Fannie P. Gregory Jenkins ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important; If item 27 is any injury or other trau once. Lawrence Pannell-Son 1500 N. 8th Street Phila, PA 19122 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 5 Other (Specify) 1/25/2011 Balto, MD 4 Donation Greenmount 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 23a. Part 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due o (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions Examiner Directo (or as a nonsequence or, cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physiclan: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) d by the at detached f 2 No 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed certificate has 2 No 2 No 1 TYes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 12 Yes Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 No 1 Inpatient 2 KER/Outpatient 3 DOA မ After this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural s after death.

I Director: Aft id in by the fu 1 Tes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hou

To the Fune

completely fi and manner stated

Division of Vital Records, P.O. Box 68760, 😿

Baltimore, Maryland 21215-0036

State Registrar

Chandke 31. Date filed (Month, Day, Year) Registrar's Signature

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 3a) (Type, Print)

RAD

29c. License number

RES- 000

29d. Date signed (Month. Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

14 2011

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend #20b Per FH G911 1/31/2011 JH State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name First, Middle, Last 2. Date of Death 3. Time of Death Physician/ Month a Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice Randa11stown Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min. 148-10-0794 Apr. 22, 1919 91 Director Yrs Pennsylvania Usual Residence of Decedent 28a-f shov 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Baltimore 1 Yes 2XXNo 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral with. 23a 3803 Victoria Ave. 21244 U.S.A. items ; filed within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, d Forces Black, White, etc. 1 Never Married XXMarried XX Yes 2 No
If Yes, Give
Year or Dates. WW II "natural", or ģ Baltimore, Maryland 21215-0036 1 Yes XXNo Specify. White 3 Widowed 4 Divorced Completed Specify event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 <u>Manaqer</u> <u>Variety Store</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Russell H. Carter Lillian L. Badgley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other training. Edith Mary Carter / Wife 3803 Victoria Ave. Baltimore, MD 21244 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest
Veterans Cemeters 20a. Method of Disposition Date 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 6 ☐ Other (Specify) Owings Mills, MD Fyneral Scrvice Licens 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. Repord mun 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) o (or as a consequence of Examiner Sequentially list conditions Examine Directo (or as a consequence of): if any, leading to in mediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ cate has been signed by the atter page 2 should be detached for in the past 12 months? Month Pregnant at time of death Dav Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? certificate 2 🗌 No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital: 2 No Certificate: To 1 🗆 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4
Nursing Home 5 Residence Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Natural 5 Pending iniurv Investigation 6 Could not be the Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a To the Funeral I Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier пpleted (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License number who completed cause of death (Item 23a) (Type, Print) Name and address of person IJ State JAN 2 4 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 20, 2011 7:29 A.N January Irene Katherine Cooper /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 2104 Drummond Road Catonsville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Hours Davs Months 1 □ M 2 👿 F 215-28-6389 31. 1928 Maryland Director 82 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Mardial Explicit market by notified an once. 1 ☐ Yes 2 TX No MD Baltimore Catonsville Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 2104 Drummond Road 21228 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🔀 No ρ Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retail 12 Make up Artist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edna Woodell Dewey Edward Bozman ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5747 Richardson Mews Square; Relay, MD 21227 Brent Cooper 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 反 Burial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery 1/24/2011 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licensee MOIDS 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sta disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Congestiv Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 C Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 4 Pregnant 5 ☐ Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ੬ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 DNo 1 ☐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) å Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 12 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 24 Medi and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 063188 M.D.

State Registrar 31. Date filed (Month, Day, Year)

24

516 N. Rolling Rd Swift 107

Catonsville

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 2011 3:00 Martha Alice Curry January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Shady Grove Adventist Hospital Rockville 3 Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗓 F Months Days Hours July 12, 1952 1120 58 Washington, D.C. 216-60-4466 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 10d. Inside City Limits 1 Yes 2 X No Maryland | Montgomery Boyds 10e. Street and Number 6 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a oi Examiner must be TANUARY Funeral 21800 Diller Lane 20841 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 No Specify: "natural". Completed 3 Divorced 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) Technical Specialist Telecommunications ge 1 and 2 should be filed wit of Health and Mental Hygie : If item 27 is marked other or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William L. Pratt Catherine Louise Lane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philip A. Curry / Husband 21800 Diller Lane, Boyds, Maryland 20841 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State January NAPTHA Parklawn Memorial Park Rockville, Maryland 4 Donation 5 Other (Specify) 26, 2011 21. Signature of Funeral Service Licensee

Myslatte Smph in 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc.
300 West Montgomery Ave, Rockville, Maryland 20850-2805 M01305 23a. Part 1. Other the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ encephalopathi anoxic disease or condition resulting in death) Medical Due to (or as a consequence of Examiner septicemia Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or iinjury Examiner failure acute the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the bunal-transit rena that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical malti ovgan Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Dav Year 4 Pregnant
9 Unknown 9 Dunknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by esophagea cancer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown neumonia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed 2 🗆 No Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) n 24 hours after deaur.

• Funeral Director: After this ce noleted filled in by the funeral director. Hospital 1 Ves 2 No Other: ပ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of ë 28c. Injury at work? 28d. Describe how injury occurred Watural 5 Pending Certificat 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c License number 00066656 0.0. takeye 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 medical center Drive, Rockville, Manyland Fakeye, MO 31. Date filed (Month, Day, Year, 32. Registrar's Signature State

Registrar

M DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month David Lloyd Cole, Sr. 18. 2011 P M January 8:40 Medical 4a. Facility Name (if not institution, give street and number) 4b City Town or Location of Death Examiner 4c. County of Death Suburban Hospital Bethesda Montgomerv 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Months Days Hours Min. Month, Day, Y 1 🕅 M 2 🗆 F Director 577-28-7376 87 Yrs Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2 X No Montgomery Potomac 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 7809 Pearson Knoll Place 20854 United States items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ò þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural" Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Minister Church Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Carlton Cole Annie Clarke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Sharon Johnston/Daughter 7809 Pearson Knoll Place, Potomac, MD 20854 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Park Tawn Park
Memorial Park 1 X Burial 2 Cremation 3 Removal from State January 4 ☐ Donation 5 ☐ Other (Specify) 2011 Rockville, Maryland 21. Signature of Funeral Service Licer R&bertandAddrepumphrey Funeral Home, thevy thase, Inc. -lauan May M01530 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between
Onset and Death
Days Immediate Cause (Final Ph sician/ Aspiration Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Parkinsons Disease 4 Years Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of Examir cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ igned by the atte in the past 12 months? Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Acute Myocardial Infarction 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy certificate 2 🗓 No Yes or Attending Physician: 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) <u>P</u> 1 ☐ Yes 2 XNo Other: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be after deatl the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check Certifying Nurse Practioner: To the best of my knowledge, do 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) D07147 January 19, 2011 30. Name and address of person who completed cause death (Item 23a) (Type, Print) 5530 Wisconsin Avenue, Chevy Chase, Maryland 20815 Nimetz. M.D Allen A.

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JAN 2 4 2011

2040

32. Registrar Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Wei Kwan 2011 Chan January 3:23 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) **China Funeral** 8. Date of Birth July 25, 1 □ M 2 🛛 F Months Days Hours Director 289-78-2988 88 Usual Residence of Decedent 28a-f shov ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Directo Maryland Montgomery Rockville 1X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 199 Rollins Avenue, #619 20852 United States death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🕅 No Specify: "natural", 3 X Widowed 4 □ Divorced Specify: Asian Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry d Mental Hygiene. marked other than Elementary/Seconday (0-12) 12 College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) and Mental I permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked cary injury or other traumatic events. ျ Wan Pang Chan Siu Ying Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeany Mark / Daughter 14733 Pommel Drive, Rockville, Maryland 20850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State January 23 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park 2011 Rockville, Maryland 21. Signature of Funeral Servi Licenses Robert A. Pumphrey Funeral Home/Rockville, Inc. Max tette Bro M01305 300 West Montgomery Avenue, Rockville, Maryland Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Hypoxic Brain Injury Non Traumatic disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Hypoglycemic Brain Injury Non Traumatic Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Euroral Director: After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burlar-transit Aspiration Pneumonia that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hypoxic Respiratory Failure Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 X No 5 Other (specify) Month Pregnant at time of death Day g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🕅 No မြ Other: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred 1 X Natural (Month, Day, Year) 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Funeral L Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 66264 January 18, 2011

DHMH 17 Rev 7/2009

State Registrar 8600 Old Georgetown Road, Bethesda, Maryland 20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

Babak Pirouz, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	aryland /		artment of Healtl <i>tificate of Deatl</i>		ental Hy		001	1 0100-
			Decedent's Name (First, Middle,	Last)					2. Date of De	Reg. N	10.	3. Time of Death
	Physicia Medic			ard Dorsey	, Jr.	, Jr.				y 2.	lay 2011 ear	
	Examir	er	4a. Facility Name (if not institution, o	4b. City, Town, or Location of De			on of Death		4	c. County of Dea		
- PET (S	Funeral	-	Montgomery Ge 5. Social Security Number 16		rthday)	01ney	ler 24 Hrs.	8. Date of Bir			gomery	
	Director		217-56-3809	1 X □ M 2 □ F	60	Yrs.	Months Days Hours		OCT. I	Year)	1950	rthplace (State or Foreign ountry) MD
and	show I at	٥	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Lo	cation					10d. Inside City Limits
Maryla	28a-f	Funeral Director	MD Howa	rd			Cooksvil	le				1 ☐ Yes 2 ĀNo
th the	3a or t be n	al D	10e. Street and Number	11 D			10f. Zip Code			10g. C	Citizen of What C	•
eath w	ems s	nue	2024 Millers Mi	12. Was Decedent B	Ever in U.S.	13. V	Vas Decedent of Hispanic (Origin? (Spec	ify Yes or No-			USA
21215-0036 within 72 hours after death with the Maryland	Hyglene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 🗓 Marrie 3 ☐ Widowed 4 ☐ Divorced	16.74- 0		"	f Yes, specify Cuban, Mexic ☐ Yes 2 ☐ No Speci	an, Puerto R	lican, etc.)		14. Race - Ame Black, Whit	te, etc.
hours	natura lical E	Completed	15. Decedent	s Education	1968-72	-	X lent's Usual Occupation			165	Specify: B1 Kind of Business	ack
21 5	han "i e Med	omp	(Specify only highest Elementary/Seconday (0-12)	grade completed) College (1-4 or 5	i+)	(Give k	aind of work done during ma O NOT use retired)					·
nd 21 filed with	Hygier other t ent, th	Be C	12 17. Father's Name (First, Middle, Las	+1	Ma	int	enance Engine				Public_	Schools
Maryland 21215-0036 2 should be filed within 72 hours after	and Mental is marked o	2	Leon Edward	,			18. Mo		(First, Middle, T. Ho			
Man	ir Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship				g Address (Street and Num					
	Health tem 27 other tra		Mrs. Bessie E. D	orsey (Spou			Millers Mill				<u> </u>	
Page 1	nt: If i		1 → Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		cemete	ry, crem	k Cemetery	1/27/	ate 2∩11		-ocation - City or ${\sf oksville}$	
Baltimore , permit. Page 1 and	Department of Important: If any injury or once.	1	21. Signature of Funeral Service Lice	ensee /		22.	Name and Address of Fac	ility HAI	GHT FU	NER/	AL HOME	
4 0,1	7 = 60	-1	23a. Part 1. Enter the disease, or co	1 1 2 2	100769		PO Box 195 Sy				L /84	
Ph	sician/		Immediate Cause (Final	/ One cause on each line								Approximate Interval Between Onset and Death
N	ledical aminer	ĺ	disease or condition resulting in death)	a. Due to (or as a	SCLER Consequence	of):	CARDIOVASO	CULAR	1156	FAS	2	SUDDEN
LA	2.	, d	Sequentially list conditions	HUPA	ERTEN	1510						Vearl
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cate be	physici the bu	edical		d								
ertific	nding page as		F FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	of pregnancy							-
death o	To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live Birth 2 4 Pregnant at 9 Unknown	2 🗌 Fetal death		Ectopic pregnancy Other (specify)		·		23d. Date of del Month	livery Day Year
hat the	ed by t		Part II. Other significant conditions	contributing to death bu	ıt not resulting i	n the un	derlying cause given in Par	t I.	23e, Did to	bacco	use contribute to	the cause of death?
dS, I	en sign	ted by										robably 4 Dnknown
e law requires	as be	Completed							24a. Was a		24b. Were aut	topsy findings available completion of cause of
r ihe	icate h		OF W			_			perfor	rmed?	death?	2 No
Sicial	s certification	To Be	25. Was case referred to medical examine ? 1 ✓ Yes 2 ☐ No	Hospital:			26. Place of De					
Physical Phy	ter this		27. Manns of Death	28a. Date of injury (Month, Day,		ime of njury	28c. Injury at		 5 Resident Describe home 		Other (Special of the Control of the	ify)
tendir death.	the fu	Certificate;	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigati 3 ☐ Suicide 6 ☐ Could not	on he			work? M 1 ☐ Yes 2 ☐	□ No			_	
al or Al	d in by		4 Homicide determine		y - At home, far (Specify)	rm, stree	et, factory, office	28	f. Location (Si City or Town			ral Route Number,
lospita 4 hours	unera ed fille	Medical	29a. Certifier 1 Certifying Ph	ysician: To the best of n	ny knowledge, o	death oc	cured at the time, date and	l place, and o	due to the cau	ise(s) ar	nd manner as sta	ited.
o the Frithin 24	o the l		only one) 3 Certifying by	rse Practioner: To the b	est of my knowl	edge, de	gation, in my opinion, death cath occurred at the time, dat	te and place,	and due to the	cause(s	s) and manner as	stated.
⊢ ≥			John Jo	5/1	M		D 00304	14		7	te signed (Month	
	10	3	0. Name and address of person who	completed cause of dea	ath (Item 23a) (T	iype, Pri	nt)				MARY &	-1,2011
	0	-	1. Date filed (Month, Day, Year)	mD 18	101 PR11	V66	PHILIP V	2,0	LNEY	, ,	MD	
F	State Registra		IAN 9 4 2011	32. Registrar	s Signature	1.1		/	,			
			GITTE A - CUII	CERCHI S.	CHALL							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** A^{M} Ross Ainsworth Dierdorff 9:35 January 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death 4c. County of Death Examiner 241 Anchorage Drive Annapolis Anne Arundel 9. Birthplace (State or Foreign Country) California 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F Months Days Hours Min 1922 24, Director 563-38-2324 88 Aug Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Annapolis MD Anne Arundel 72 hours after death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
USA ō 21401 34 Randall Street 23a Funeral items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Armed Forces? 1940-1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 0 Specify: white 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify. þ 1945 3 Widowed 4 Divorced natural Completed Department of Health and Annual be filed within 72 i Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natu any injury or other traumatic event, the Investment once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) teacher education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ross Ainsworth Dierdorff Nellie Eileen Baker ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Thomas - daughter 241 Anchorage Dr; Annapolis, Maryland 21409 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation _5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board 21. Signatury of Euneral S. Vice Licensee 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease or complications that caused the or heart failure. List only one cause on each line. 23a. Part 1. shock ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate C (Final **Physician** disease or condition resulting in death) TRELLINE /Medical Due to (or as a consequence of): Examiner Due to (or s a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) buria Box 68760, physician Physician/Medical the attending asn. IF FFMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 5 Other (specify) P.0. ed by the detached f 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, s been signe should be a \$ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page Physician: The 2 🖺 No 2 UN6 1 □ Yes director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Thesidence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attending 1 Natural 5 ☐ Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deat Funeral Director: the Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

Date filed (Month, Day, Year)

4

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend #20a-c &22 Per FH G912 2/01/2011 JH State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. Nó 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Epperson Napoleon jan 21:07 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Univ of Maryland Medical Battimore Center If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 ☎ M 2 ☐ F Months Days Hours Min. Feb 28, Maryland **Director** T956 219-62-4699 54 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits Director 1X Yes 2 ☐ No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 21217 USA 2208 Brookfield Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 2 Yes 2 No 1976-If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc 1X Never Married 2 Married Baltimore, Maryland 21215-0036 black 1 ☐ Yes 2 X No Specify: If Yes. Give 1979 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) CNA 12 healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Napoleon Bernard Epperson Sr. Gladys Epperson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Napoleon Epperson III - son 930 Seagull Avenue; Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial XX Cremation 3 Removal from 4 Donation 5 Dotation (Specify) cemetery, crematory or other place) Crownsville Vet. Cem: 1/20/2011 Crownsville.MD ature of Funeral Service Licens Philip Weatherford run Ser 2431 655 W. Baltimore St; Baltimore, any t 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Squamous CARCINONA INVASIUE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown cate has been sig page 2 should b Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? After this certificate funeral director, pag Yes 2 N 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 10 1 Yes 2 X No 1 📈 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending in 24 hours area wheeling the Funeral Director. After an Interest filled in by the fur 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certific 29d. Date signed (Month. Day, Year) 14/2011 10069 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ballmore 22 81. MD E DUARNS 5 Greens 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State ark 2 4 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 19, 201 T 11:00 AM Evans Helen McSorlev Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll 1510 Stone Road Westminster 8. Date of Birth (Month, Day, Year) April 14,1934 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🗓 F **Director** 76 213-30-8270 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ä Director Examiner must be notified 1 Yes 2 No MD Finksburg Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3230 Jeffrey-Lori East 21048 items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. .0 1 ☐ Yes 2 🗓 No If Yes, Give 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ♣ No Specify. permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", Specify: 3 Midowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Office Manager General Contracting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edward Manger Anna Mary McSorley Harmon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kimberly Anne Haker-Daughter 3230 Jeffrey-Lori East; Finksburg, MD 21048 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State any injury or 1 X Burial 2 Cremation 3 Removal from State Garrison Forest 2/4/2011 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 . Dignature of Funeral Service Licen-00 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one call and Death Gean Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) ^fExaminer Sequentially list conditions Examine if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) that the death certificate be execute attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) Pregnant at time of death Yes 2 No the 9 Unknown 9 Unknown P.O. I s been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy perform Hospital or Attending Physician: The 1 🗌 Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation within 24 hours after death

To the Funeral Director:,
completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 31. Date filed (Month, Day, Year)

JAN 2 4 2011

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 1 State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 - For State Registrar Friedel 1. Decedent's Name (First, Middle, Last) Joan Paska 2. Date of Death 3. Time of Death Month Physician/ Day (Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕏 F Months Davs Hours Min. 10/12/1931 Country)
Maryland 79 212-30-7802 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Examiner must be notified at Director 1 Yes 2 No Maryland Woodstock Howard 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ö Funeral items 23a 10801 Enfield Drive #120 21163 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14 Race - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Law Attorney Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bertha Sumoski Stephan Paska 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Beth Friedel - Daughter 1228 Swan Hill Court Chesnut Hill Cove, MD 21226 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place) Holy Rosary Cemetery | 01/14/2011 | Baltimore, Maryland Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
David J. Weber Funeral Homes P.A. S. Chester Street Baltimore, Maryland 21231 Part 1. Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and De Immediate Cause (Final Physician/ LARGE INTRACKANIAL HEMORRHAGE WITH HERNIADION 17 HOURS disease or condition resulting in death) Medical Examiner 17 Hours TRAVENTRICULAR HEMORRHAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner SUBBURAL HEMATOMA HOURS Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical HOURS VASOGENIC EDEMA Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death the 9 Unknown 9 Unknown been signed by should be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably SUnknown Completed has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? this certificate 1 🗌 Yes 2 🗌 No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? Natural Accident injury 5 Pending in 24 hours arter com...he Funeral Director: Aff Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 5 b.D.

Registrar

State

4940

EASTERN AVENUE, BALTIMORE, MD 21224

OWEG, D.O.

Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A

2011

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MARGARET

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

Maryland Baltimore			Registrar	ficate of Deat	1		Reg. No.	In Time of Booth		
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if any, leading to immediate cause. Enter Underlying Causes or injury that initiated events resulting in death) Last Table Last	Medical	1	failure. List only one cause on each line. Immediate Cause (Final disease a Alcohol and Ox				rrest, shock, or heart	Between Onset an		
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28b. Was decedent pregnant in the past 12 months?		Ë	cause. Enter Underlying Cause (Disease or injury that initiated							
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29c. License number 29c. License number O.C.M.E. O.M.E. January 16, 2011	e Hos 24 hc e Fun		Check only 1 Certifying Physician; 10 the best of my knowledge, of	death occurred at the	time, date and pla	ce, and due to the cau	use(s) and manner as sta	ted.		
O.C.M.E. OOME January 16, 2011 30. Name and address of person who completed cause of death (tem 23a)	To th withir To th compl	ed	and manner stated.			Julieu at the time, date				
30. Name and address of person wito completed cause of death (frem 23a)		2	Zor. Signature and the or certains	7 290	,	DOME				
	& C		30. Name and address of person who completed cause of death (Item 23)	(a)			1			
1 Theodore in Thing, 41., M.D. Theodoric Induction Examiner 500 41. Data filed Cities, Data filed Cities, Data filed Cities, and Election	pere			•	Baltimore Stre	eet, Baltimore, M	ID 21223			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JANUARY 14 2011 РМ Sherman Huggins 0.0 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SAINT JOSEPH MEDICAL CENTER TOWSON BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign (Month Day, Year) Sept 22, 1945 1 🖾 M 2 🗆 F Hours Maryland Director 215-40-7197 65 Usual Residence of Deceden 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Towson 1 Yes 2 No MD Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21204 7001 N. Charles St. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 black 1 ☐ Yes 2 No Specify: If Yes, Give 3 Divorced 4 X Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 0 Baltimore City sanitation worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Margarite Huggins . Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tracy Huggins - daughter 643 E. 36th St; Baltimore, Maryland 21218 Baltimore, 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) in state cemetery, crematory or other place) Sign of Fundral Service Licensee 22. Name and Address of Facility State Anatomy Board /Director 655 W. Baltimore St; Baltimore, MD 22 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, SEPSIS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner CLOSTRIDUM DIFFICILE COLITIS Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and I for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş END STAGE RENAL DISEASE Completed 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? After this certificate 1 Yes 2 No Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital: 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation Director: / 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the hest of my knowledge, death undures within 2 To the I date and black 29b. Signature a 29c. License number 29d. Date signed (Manth, Day, Year, D24034

State Registrar 30. Name and address of person who couple

TIMOTHY LOW M.D

31. Date filed (Month, Day, Year)

7601 OSLER DRIVE TOWSON, MD 21204

d cause of death (Item 23a) (Type, Print)

32. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2 Month Year 12a beth 150 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death izabeth wsing ente more If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State of Months Days Hours Min. November 17, 1932 Mary Land Social Security Number 7. Age (In rs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 F 218 28 4801 78 **Director** Yrs. Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 XXX Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6027 Chesworth Road USA 21228 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc. Completed by 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes XXXX Specify: Specify.White If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Henry Hitte1 Fuhrmaneck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Debra Zanti / Daughter permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 3923 Brittany Lane, Hampstead , Maryland, 21074 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory or other place) 1/24/2011 Glen Burnie, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facilit Gary L. Kaufman Funeral Home, Inc. 7250 Washington Blvd..Elkridge.Maryland,21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one of use on each line. Approximate use on each line. Interval Between Immediate Cause (Final Onset and Death COL Physician/ carcinoma disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** me Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Due to (or as a consequence of) resulting in death) Last bunialattending physician for use as the buria Physician/Medical that the death certificate be 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Box in the past 12 months?

1 Yes 2 No
9 Unknown Dav ed by the a s been signed by should be detr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 1
 24 hours after death.
 Funeral Director: After this certificate has hoon simm Records, 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 25. Was case referred to medical examiner? **Division of Vital** within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 2 Acciden 3 Suicide 5 Pending Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗥 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) anuar of death (Item 23a) (Type, Print) Name and address of person who completed cad 3320 NP uson 31. Date filed Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) January 20, 2011 10:40 A. M Physician/ Albert A. Hussein Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** N/A Baltimore 2808 Goodwood Road 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number **Funeral** Months Days 1 X M 2 - F Hours Min November Day, 1 Palestine 13 1920 504-52-3485 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10b. County 10c. City, Town or Location 10a. State at Director 1 🛚 Yes 2 🗆 No of Health and Mental Hygiene. item 23a or 28a-fs in mem 27 is marked other than "natural", or items 23a or 28a-fs other traumatic event, the Medical Examiner must be notified Baltimore N/A Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21214 Funeral 2808 Goodwood Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces?
1 ☐ Yes 2 🔀 No 1 Never Married 2 Married Completed by within 72 hours after White 1 ☐ Yes 2 🙀 No Specify: If Yes Give 3 XWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Salesman Be 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Hy Important: If item 27 is marked other any injury or other through 17. Father's Name (First, Middle, Last) ပ္ Arifa Jarrar Abdulla Ali Hussein 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4413 Bedford Place Baltimore Maryland 21218 Yasmin Dolan/ Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition emetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Towson Maryland Hilltop Service Corp 1/24/11 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit Leonard J. Ruck, 1 5305 Harford Road Signature of Funeral Service Licenses Tnc. Baltimore Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as correspiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) many Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): ng physician and as the burial-tran Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical IF FEMALE: fyes, outcome of pregnancy □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy nse 23b. Was decedent pregnant ☐ Live Birth 2 ☐ retail use.☐ ☐ Pregnant at time of death Month Year in the past 12 months? Day for Yes 2 ☐ No signed by the at d be detached fo 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy s certificate has I performed? Yes 2 \\ No 1 🗌 Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

Maryland 21215-0036

3altimore.

within 24 hours a To the Funeral C

27. Manner of Death

Natural

29a. Certifier

Accident

3 Suicide

only one) 29b. Signature and title of cer

5 Pendina

Investigation

determined

6 Could not be

State Registrar

10

Medical

ho completed cause of death (Item 23a) (Type, Print)

28a. Date of injury (Month, Day, Year)

10657105

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28c. Injury at work? 1 ☐ Yes 2 ☐ No

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

4565 N Charles

28d. Describe how injury occurred

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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н	Physicia	n/										Year	3. Time of Death	
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89	certific nding use as	Σ	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of <u>pr</u> egna	ncy					230	d. Date of del	verv	
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	he Ho in 24 I he Fu pletec	29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 12 (Month, Day, Year) 12 (Month, Day, Year) 13 (Month, Day, Year) 14 (Check only one) 30 (Dertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 12 (1) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. S. Rajapak KR MD 283.5 Smith Av. S. 703 - Balbimore, MD. 212 09.										ause(s) and manner sta stated.	ated.	
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	7	- 1	30. Name and address of person of Ray apa K	vho completed cause of HMD 7	835 S	23a) (Type, Pi	int) -v - S - 703	3 - 3	Saltin	non , M	10.2	1209	4	
	Stat Registra	e r	31. Date Alexi (Mantta Day, Year)	Senera 32. Regi	strar's Signati	ure								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 15&18 Per FH G911ack Indelible Ink. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No... 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Bruce Month Day Year HURL mugey 21:44 /Medical 20 2011 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HORKINS BAYUIEW TIMORE 11 Year | If Under 24 Hrs. 5. Social Security Nu 215–60–50 Funeral 7. Age (In yrs. last birthdav) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**X** M 2□ F Months Days Hours 57 Director February 13,1953 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show r than "natural", or items 23a or 28a-f shov the Madical Examiner must be notified at Director Maryland N/A 1 Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 326 Gusryan Street 21224 USA Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 years Director of Operations Cable other 17. Father's Name (First, Middle, Last) ¹⁸AngelamMary Caltagirone Angelina Caltarigone Be 27 Is marked traumatic e Robert M. Hurley ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Theresa Yermal Friend 1912 Tyler Road, Dundalk, Maryland 21222 other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State January permit. Pages Department of Important: If It any Injury or c once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 24, 2011 Signature of Funeral Service Licenses Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, brily one cause on each line. . Part 1. Enter the disease or shock, or heart failure. List Onset and Death Immediate Cause (Final Massive Bleeding Physician 2 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed burial-transi Intravasadar Couguloprothy 9 days 215 Seurnate Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 D Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 5 ☐ Other (specify) P.O. the detached 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ icate has been si 2 No Completed 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 28 No certificate Division of Vital 1 ☐Yes 2 ☐ No 1 □Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred or Attending 5 Pending investigation 1 Natural within 24 hours after common to the Funeral Director: Aft 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10.112 Crackin Ave Balfmare MD 201 31. Date filed (Month, Day, State Year! JAN 24 2011 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State of Maryland / Des Amend Item 27 per dr., g911,0	ያሟጧዎ <mark>ያአ</mark> የ ፤ ዘር βlth and Mental Hygiene ertificate of Death Reg. No. 2 በ በ 2 (
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year 3. Time of Death
	/Medic		Otto Peter Hegedus	January 3 2011 7:06 A M
	Examir	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Death
_	F1	_	18421 Crownsgate Circle 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Germantown Montgomery
	Funeral Director		121-78-7367 ^{1⊠M 2□F} 59 Yrs.	Nonths Days Hours Min. Months Days Hours Min. State of Birth (Month, Day, Year) State or Foreign (Country)
	pr ,		Usual Residence of Decedent	
	arylar shov	'n	10a. State 10b. County 10c. City, Town or l MD Montgomery Germant	The state of the s
	the M	Director	10e. Street and Number	
	Sa or	ā	18421 Crownsgate Circle	10f. Zip Code 10g. Citizen of What Country? 20874 USA
	ms 2:	Funeral		Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, its Medical Evaniral runs or nothing at	Ď	1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No 1 ☐ Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ☑ No Specify: Black, White, etc. Specify: white
2	72 h	etec	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation unk 16b. Kind of Business/Industry unk e kind of work done during most of working
2	within ene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)
0	filed Hygin	ပိ	unk unk 17. Father's Name (First, Middle, Last) unk	18. Mother's Name (First, Middle, Maiden Surname) unk
au	lid be lental ked c	To Be	dik	unk
ary	shou and N s mar	-	19a. Informant's Name/Relationship (Type. Print)	ing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Σ.	and 2 ealth n 27 I		Aranka Galos - friend 18	421 Crownsgate Cir; Germantown, Maryland 20874
Baltimore,	permit. Pages 1 Department of H Important: If iter any Injury or ott		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) In State	osition (Name of Date 20c. Location - City or Town, State ematory or other place)
Balt	permit. Depart Import any Inj once.		21. Signatu en Funeral Service Ucensee	22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201
			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock or heart failure. List only one cause on each inc.	nter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between
	Physician		Immediate cruse (Final disease or condition	Onset and Death 7 mm Tts
1	/Medical Examiner		resulting in death) Due to (or as a consequence of):	
	1	ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	
	d d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):	
o	icate be executed physician and the burial-transit	Exa	resulting in death) Last C. Due to (or as a consequence of):	
8/60,	ate be hysici he bu	dical	d	
9	certific nding p	Med	IF FEMALE:	
ŭ	death e atter	Physician/Me		□ Ectopic pregnancy 23d. Date of delivery □ Other (specify) Month Day Year
ras, r	To the hospital or Attending Physician: The law requires that the of within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did tobaccouse contribute to the cause of death? 1 ☐ es 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
ecord	aw rec	olete		24a. Was an 240. Were autopsy findings available
VII A	uing Physician: The is no in the is no in the is After this certificate ha funeral director, page to increase in the interest of the interest of the increase in the interest of the increase in the increase in the interest of the increase in the interest of the interest	e Completed	25. Was case referred to the rical	autopsy performed? prior to completion of cause of death? 1 □ Yes 2 ☑ No 26. Place of Death (Check only one)
> -	nysica nis ce direc	TO B	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ PR/Outpatie	Other
Ö .	ng Pt ftert ineral	ü	27. Manner of Death 1 A Natural 5 Pending 28a. Date of Injury (Month, Day, Year) Injury	
SION	tendi leath. tor: A the fu	cati	2 Accident investigation 3 Suicide State Accident State Suicide State Suicide State Suicide State Suicide State Suicide State Suicide	M 1 ☐Yes 2 ☐No
בו ב	Ital or At Irs after o ral Direct Iled in by	Certification:	4 Homicide determined building, etc. (Specify)	City or Town, State)
	lo the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 Medical Examiner: On the basis of examination and/or i	th occurred at the time, date and place, and due to the cause(s) and manner as stated. nvestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
,	oo vit	=	29b. Signature and title of centifier	29c. License number 29d. Date signed (Month, Day, Year)
		-	30 Name and address of person who completed cause of death (Item 23a) (Type	Print)
	Stat		30 Name and address of person who completed cause of death (Item 23a) (Type, 1. Date filed (Month, Day, Year) 32 Registrar's Signature	D, 29 South Greene St. Ballom
	Registra	٠ .	JAN 2 4 2011 Celeva B. Sa	allal

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Earlene Hammonds Month January 5:20 P M 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death
Bultmone easurs Hospite a NW Hospital Randallstown Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 7:34.07 1 - M 2 X F (Month, Day, Director NC Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Baltimure Windsor Mill 1 🗆 Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Durt 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Black Completed 3 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th arade eacher 5+ years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Earl Hunter Helen Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) erry Hammonds, Jr. Court Windsor Mill, MD Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 01/19/2011 King Memorial Park Windsor Mill, MD 4 ☐ Donation 5 ☐ Other (Specify) Greene Funeral Services 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughn all sown MD 21/33 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Hepato-Renal Syndrome Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated example. Examiner Due to (or as a consequence on attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No 1 Yes 2 Unknown Pregnant at time of death Month After this certificate has been signed by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ည 1 ☐ Yes 2 🗹 No Other: 4 Nursing Home 5 Residence 6 Pother Specify Trent helpic 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 \(\text{Yes} Accident 2 🗆 No Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MSKY apakrem. D 1/13/11 10057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimorr, MD. 21209 N.S. Rajapakte, M.D. 2835 Smith Av-5-203, 31. Date filed (Month, Day, Year) State 2. Registrar's Sign Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc gold 1-28 to Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Charles Raymond Jackson 2. Date of Death Physician/ 2011 1:30 Ам January Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick <u>Frederick Memorial Hospital</u> Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign Country) MD Year 19<u>34</u> Days Hours Oct. 23 219-28-3671 Director 76 Usual Residence of Decedent 28a-f shov 10a. State event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo 1 🗆 Yes 2 🗓 No MD Howard Woodbine 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 14787 Addison Way 21797 items 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, by Black, White, etc. ō 1 Never Married 2 Married 1 ▼ Yes 2 □ No If Yes, Give Year or Dates. 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", **Black** 3 XWidowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Detergent Plant Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Jackson, Sr. Harriet Elizabeth Dorsey of Health and Me
of Health and Me
fitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Julia Polk (Sister) 14787 Addison Way Woodbine, MD 21797 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of F
Important: If ite
any injury or ot 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Bushy Park Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 1/25/2011 Cooksville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 400764 PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ ☐ Live Birth
☐ Pregnant
☐ Unknown in the past 12 months? Month Pregnant at time of death Day Year signed by the a d be detached f Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an To the negative version within 24 hours after death.

To the Funeral Director, After this certificate has I completed filled in by the funeral director, page 2. autopsy 1 Yes 2 No ☐ Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 2 🖫 No 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident
Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Me lical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one 3 Certifying Nurse Praction recurred at the time, data and place, and due to the caucaje) and manner ac stated. 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed eause of death (Item 23a) (Type, Print) MD Strad 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b Per FH G912 2/04/2011 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Tanyany Month 1,06 Oil Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A 7. Age (In yrs. last birthday) **Funeral** 5. Social Security Number 212-34-8199 If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 1 □ M 2 🕱 F **Director** Ja'n Delawa_{re} Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland notified at 10c. City, Town or Location Director 10d. Inside City Limits N/A MD Baltimore 1X Yes 2 No ö 10e Street and Number 10f. Zip Code "natural", or items 23a or edical Examiner must be 10g. Citizen of What Country? Funeral 2830 Ashland Avenue 21205 USA permit. Page 1 and 2 should be filed within 72 hours after death be Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ģ 1 Never Married 2 Married Black, White, etc 1 ☐ Yes 2 X No If Yes, Give 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Johns Hopkins Elementary/Seconday (0-12) 12th College (1-4 or 5+) N / A Housekeeping Hospital Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Mansel Wilson Watson Norma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yolanda Joyner/Daughter 2830 Ashland Ave. Balto.,MD 21205 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 2/03/2011 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place Garrison Forest 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, MD Signature of Funeral Service Licenses 22. Name and Address of Facilif Beverly D. Cromartie F/S 2700 Edmondson Ave-Balto., MD 21223 and 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Filysician/ disease or condition Medical resulting in death) [∄]Examiner Sequentially list conditions Se puentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events assisting in death) I ast Examiner attending physician and for use as the burial-transit resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 🚾 o 3 ☐ Probably 4 ☐ Unknown FlonVator 24a. Was an 24b. Were autopsy findings available Jas performed? prior to completion of cause of death?

1 Yes 2 No Yes 2 N To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 1 npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury Accident Suicide Investigation 1 🗌 Yes within 24 hours after deat To the Funeral Director: 6 🗆 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. address of person who completed cause State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month JANUARY 201 Jones 20 18:06 PM Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death JOHNS HOPKINS BAYVIEW HEDICAL CENTER BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 3, 1942 **Funeral** 9. Birthplace (State or Foreign Months Days Hours 214-40-7722 Director 68 Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits Maryland Baltimore Dundalk 1 Yes 2 XNo 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 7026 Dunbar Road USA items 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. within 72 hours after ò ð 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White "natural", 3 Widowed 4 Divorced Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Eye / Vision 12 years Optision Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Robert Jones Mae Jeanette Lawrence permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert E. Jones 436 Cooley Mill Road, Havre De Grace, MD. 21078 son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State January 1 Burial 2 Cremation 3 Removal from State Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21, 2011 Signature of Funeral Service License Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Physician/ ARAHYTHMIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 5 DAYS CARDIO HY OPATHY Sequentially list conditions, if any, leading to immediate cause Enter or merging Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit I WEEK To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit ISCHEMIC COLITIS that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Be (25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 📉 No Hospital Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending ☐ Accident ☐ Suicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signat 29c. License number 29d. Date signed (Month, Day, Year) **RES-000** JANUARY 20, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Q M.D. BURNS 4940 EASTERN AVENUE WILLIAM R. BALTHORE, MD 31. Date filed (Month, Day, Year)

JAN 2 4 2011 32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mary Lee Kegg Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Allegany Western Maryland Health System Cumberland If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jan 30, 1939 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖾 F Months Maryland Director 215-36-7637 Usual Residence of Decedent or 28a-f show 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits Director Cumberland 1 ☐ Yes 2X No MD Allegany 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 USA 1807 Holland Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 ₺ No Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) teacher education Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) 2 Rose Ann Morgan Charles Lee Jolley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1807 Holland St; Cumberland, Maryland 21502 <u>J. Thomas Kegg</u> - husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 of ther (Specify) cemetery, crematory or other place) 22. Name and Address of Facility State Anatomy Board Signature of 5 in 1714 niced icen at the Director 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Pa Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician all the burial-t Physician/Medical P.O. Box 68760 attending p 3S IF FEMALE use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Multiple Sclerosis Division of Vital Records, 1 Yes 2 No 3 Probably 4 Monknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an s certificate has blirector, page 2 s autopsy performed? Yes 2 No 1 Yes After this certification, I 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital: 2 🗆 10 Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu Accident 1 Yes 2 No Investigation Suicide 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and tit 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

Blanche Harry Maromatis 904 Seton , 'Tumberland, Md 21502

32. Registrar's Signature

ENES VALO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 January Bertie Kiser 11:50 A M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Howard Sunrise Assisted Living Columbia Social Security Number 9. Birthplace (State or Foreign Country) Virginia 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Hours Min. 03°008 217-22-1652 102 Director Usual Residence of Decedent or 28a-f shov 10a. State 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 🗆 Yes 2 💢 No Howard Glenelg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 14223 Meadow Lake Drive 21737 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 ☐ Yes 2 K No Specify. White Specify: 3 X Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) traumatic event, th-Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ၉ Andrew Floyd Deel Martha Clevenger tt. Page 1 and 2 should be rtment of Health and Mer rtant: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynda Silva (Daughter) 14223 Meadow Lake Drive Glenelg, MD 21737 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I 1 ★ Burial 2 Cremation 3 Removal from State injury (1-9-2011 4 ☐ Donation 5 ☐ Other (Specify) A.F. Deel Cemeterv Haysi, Virginia 22. Name and Address of Facility Witzke Funeral Homes, 21. Signature Funeral Service Licer 5555 Twin Knolls Road Columbia, MD 21045 23a. First 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 1 tasms Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Second at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year signed by the a d be detached f g Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2. No Yes Be Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify Assiste Living P To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of person who completed cause of death (Item 23a) (Type, Print) Name and address Lazris

Registrar DHMH 17 Rev 7/2009

State

Date filed (Month, Day, Year)

4 2011

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

(20 ar

32. Registrar's Signature

6334

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year LU WHELL 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death DM CENTOR KULTHW25, (900) 6. Sex Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1xxx M 2 □ F Hours November 28, 59 Mary Land Yrs 1951 Director Usual Residence of Decedent 28a-f show 10b. County 10a. State at 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director be notified 1 Yes 2 No Baltimore County Maryland Pikesville 5 10e. Street and Numbe 10f. Zip Code 10a. Citizen of What Country? Funeral 23a must USA 1611 Woodling Way 21208 items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces or Black, White, etc. þ 1xx Never Married 2 Married 1 ☐ Yes 2xx No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural" Completed 3 Widowed 4 Divorced Specify: white Year or Dates other than "natur 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Day Program attendee Chimes School 27 is marked othe traumatic event, Be fled \ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Doris Theresa Kreiner Henry Walter Klapp, Sr. plnods 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health 27 1413 W. 37th Street Baltimore, Maryland 21211 Doris T. Klapp Mother other item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place. 4 Donation 5xx Other (Specify) Entombrent Parkville, Maryland Moreland Memorial Park 1/22/2011 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 2121 Part 1. Enter the dispase, or co shock, or heart failure. List only pase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e. List only one cause on each line. 23a Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner DNEUMENL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Du to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed RELURAEN sician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. s been signed the should be detailed 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 ANO 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has performe death? this certificate 1 🗌 Yes 2 funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 1100 Other: 2 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann f Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred eral Director: After filled in by the funer 1 V Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide
4 Homicide ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) hours within 24 hours To the Funeral Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cettifie 29d. Date signed (Month, Day, Year) 2011 ne 30. Name and address of person who pleted cause of death (Item 23a) (Type, Print) YORTHNES

DHMH 17 Rev 7/2009

State

Registrar

ORIANDO E 31. Date filed (Month, Day, Year)

24

CONANA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1^{Day} 2ďď1 10:00 P M Duncan Lee Latimer January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Stella Maris Timonium 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
July 5, 1939 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 **X** M 2 □ F Days Hours Min. Mary Yand Director Yrs 213-36-9849 71 Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 ☐ Yes 2 🏝 No MD Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21136 55 Hanover Road 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examination þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) contractor home improvement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Duncan Latimer Carmen Murilla Tawney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
55 Hanover Rd; Reisterstown, MD 21136 Sharon Latimer - sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☑ Donation 5 ☐ Other (Specify) Signati of Funeral price Licen was de-22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ LUNG CANCER Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying To Be Completed by Physician/Medical Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Box (Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 X No nours after death.

neral Director: After this filled in by the funeral di 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 1 ☐ Yes 2 ☐ No injury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I 29d. Date signed (Month, Day, Year)

State Registrar

13,

IANUARY

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)

JACKIE JONES,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 18, 2011 2:30 P.M Libertini Julia Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Halethorpe 4949 Cedar Avenue 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Country)
Maryland 1 □ M 2 🛚 F Hours Director 1923 218 18 9713 78 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene.
is marked other than "natural", or items 93a or 980. 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2v No Maryland Baltimore <u>Halethorpe</u> 10e. Street and Number 10g. Citizen of What Country? Funeral 4949 Cedar Avenue 21227 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Book Keeper Floral 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic N.Andrew Castagnetti Gilda Maggiani 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Newcomb / Daughter Whiskey Bottom Road, Laurel Maryland, 20723 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Meadowridge Memorial 1/21/2011 Elkridge, Maryland 22. Name and Address of Facility Gary L. Kaufman Funeral Home 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on earl line.

Immediate Cause (Final disease or conditions) 250 Washington Blvd. Elkridge Maryland. 21075 Approximate Interval Between Onset and Death Pnysician HIPER CALCEMIT disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and doe detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by DEMENTIA 1 Yes 2 No 3 Probably 4 Unknown Completed peen : ATRIAL FIRRLIATION Were autopsy findings available 24a. Was an prior to completion of death? has autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes Certificate: To 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation Suicide
Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature

State Registrar 30. Name and address of person who co

4

eted cause of death (Item 23a) (Type, Print)

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Jahuary 19 2019ar Mary Madeline Leono 12:40 P_{M} Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Mariner Health of Overlea Baltimore N/A 5. Social Security Number If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** 1 🗆 M 2 🕱 F Months Days Hours 02-25-1916 ear 217-68-1051 Director 94 Yrs Usual Residence of Decedent fshow Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant If item 27 is marked other than "natural", or items 23a or 28a-f shoi ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No York Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1117 Cobblestone Court 17331 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 6 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Leono Agnes Schneider 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Ann Krout - Niece 1117 Cobblestone Court Hanover, PA 17331 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State Most Holy Redeemer Cem. 4 Donation 3 Other (Specify) Baltimore, Maryland 21. Signature 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart dailure. List only one dause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a con Examiner Sequentially liet or difficie, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day Year 2 No 9 Unknown g Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been signated bage 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe After this certificate 2 No Yes 2 No 1 Yes within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director; Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier etrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address

31. Date filed (Month,

Day,

4

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sig

Raven 13 lvd, Baltimore MD 21239

arkin, John

21237 Philam H. WONDEHOWOT 20063327 Jan, 22 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GIZAW WOLDEHINGT, MD 9000 Franklin Square Dr Baltimore, MD 21237 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Beneva S. Jack Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month January Paul E. Landis 2011 4:00 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Charlestown Care Center Baltimore Catonsville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth
(Month, Day, Year)
Feb. 19,1920 **Funeral** 9. Birthplace (State or Foreign 1 X M 2 □ F Hours 144-18-8120 New Jersey Director 90 Usual Residence of Decedent 10a, State be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location at Director 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f si any injury or other traumatic event, the Medical Examiner must be notified. MD 1 Tes 2 X No Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 719 Maiden Choice Lane **BRT206** 21228 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Force Black, White, etc. 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Physicist U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edwin Charles Landis Estelle Barto 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vivian E. Landis Wife 719 Maiden Choice Lane BRT206; Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Parklawn Cemetery Donation 5 🗆 Other (Specify 1/22/2011 Rockville, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Signalure of Funeral Se Funeral Home of Catonsville, Inc. 630 Edmondson Avenue: Catonsville 23a. Part 1. Enter the disease or complications that caused shock, or heart failure. List only one cause on each line omplications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Ph_sician/ Onset and Death disease or condition resulting in death) Medical Due to (or as a consequence **Examiner** Examiner 3d. Date of delivery Month

the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760 signed by the a certificate has been si irector, page 2 should To the Funeral Director: After this certific completed filled in by the funeral director,

Physician/Medical þ Completed Be မ Certificate:

Medical

Sequentially list conditions, if any leading to minimalists cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	b. — Due to (or as a consequence of): C. — Due to (or as a consequence of): I.d. —		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1		23d. Date of delivery Month Day Year
Part II. Other significant conditions o	ontributing to death but not resulting in the underlying cause given in Part I.		use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available
		autopsy performed?	prior to completion of cause of death?
25. Was case referred to medical examiner?	26. Place of Death (Chec	ck only one)	
1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing H	ome 5 Residence	6 ☐ Other (Specify)
27. Manner of Death Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not b		28d. Describe how inju	ury occurred
4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town, Stat	
Uneck 2 - Medical Exami	sician: To the best of my knowledge, death occured at the time, date and place, a iner: On the basis of examination and/or investigation, in my opinion, death occurred as Practioner: To the best of my knowledge, death occurred at the time, date and pla	at the time date and place	e and due to the cause(s) and manner stated

State Registrar

24 hours after

JAN 2 4 2011

only one) 29b. Signature and title of certified

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

ackelle

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Helen January 17, 2011 3:02 A^M Goodell Lowe /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, May 24, 5. Social Security Number 9. Birthplace (State or Foreign Country)
Maine 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕅 F Yrs Director 97 1913 047-28-7107 Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Directo 1 ☐ Yes 2 X☐ No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö items 23a 20814 United States 4883 Battery Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Ye ar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iter any Injury or other traumatic event, Ital Abdical Evarins and any Injury or other traumatic event, Ital Abdical Evarins Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2X No þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Winifred Pelkey 2 Roy Basil Goodell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5712 Roland Avenue, Baltimore, Maryland 21210 Susan DeRosa / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State January 20, Montgomery 4 ☐ Donation 5 ☐ Other (Specify) Cremătorium, Inc. 2011 Bethesda, Maryland 21. Signature of Funeral Service Ligensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive Heart Failure /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Electronic Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed aftending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 K No Year Day 5 Other (specify) signed by the a P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ certificate has been si irector, page 2 should Urinary Retention 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 🔀 ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) spital or Attending P tours after death. neral Director: After y filled in by the funer: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 X Natural 5 Pending Injury 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Hospital 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) amas January 19, 2011 D50534 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas M. Masterson, M.D 1313 Dolly Madison Blvd. #302, McLean, VA 22101 31. Date filed (N 2. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

tares

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TITEM/SperFH, G911, 1/24/2011, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 20, 2011 Month ase Medical anuare Facility Name (if not institution agive street and number **Examiner** 4b. City, Town, or Location of Death County of Death ommun Security Number 8. Date of Birth
(Month, Day Year 9. Birthplace (Sta Country) Age (In yrs. last birthday) Yrs. If Under 1 Year If Under 24 Hrs. **Funeral** 1 🗆 M 2 🔀 F Days Months Hours Min Director 191-32-9861 Usual Residence of Decedent or 28a-f shov Director 10b. Count 10a. death with the Maryland injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10Wal 1 X Yes 2 No olumbia 10e. Street and Number 10g. Citizen of What Country? Funeral or items 23a 11. Marital Status 12 . Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates 2 X No 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", Completed 3 X Widowed 4 Divorced lack 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatin. College (1-4 or 5+) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Creek Dandy Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Columbia 4-2.011 Signature of Funeral Service License 22. Name and Address of Facility Vaughn & Greene Services Funeral Baltimore 5151 Nationa 23a. Part 1. Ender the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) 0 Medical Due lofor as a consequence of Examiner shaestive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph for use as the 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 2 No Other: ဂ္ 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident 1 🗌 Yes 2 🗌 No Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) pleted filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 52815 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOODLOES PROMISE DRIVE, BOWIE MD 26920 4.0.12700 ANDER ANIEL 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Lewis Robert \mathbf{P}^{M} Morris January 13, 2011 7:02 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 3918 Weller Road Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) 1 X M 2 □ F Months Yrs 365-40-5112 September 9, 1940 Massachusetts Director 70 Usual Residence of Decedent 10a. State show 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Examinar in ust be notified at Director 1XYes 2□No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1322 Veirs Mill Road 20906 72 hours after death Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 N Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Vietnam 1 ☐ Yes 2 No Specify: ş Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Farrier Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and 2 should be fi. ealth and Mental F n 27 is marked otl Be Walter Isaac Morris ပ Leona Belle Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Department of Health Important: If item 27 any injury or other tr 4116 Heathfield Cassandra Abram /Daughter Road, Rockville, Maryland 20853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages injury or January 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rockville Union Cemetery 2011 Rockville, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. Robert A. Pumphrey Funeral Home/Roc 300 West Montgomery Avenue, Rockvil

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Onset and Death Immediate Cause (Final Physician Arteriosclerotic Cardiovascular Disease disease or condition resulting in death) Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last burial-Due to (or as a consequence of): P.O. Box 68760, Physician/Medical the as attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ s been si 1 ☐ Yes 2 💆 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificate 1 □ Yes 2 □ No 2 💢 No 1 □ Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) in law s Hospital: 1⊠Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending 24 hours after death. 2 Accident investigation 1 ☐ Yes 2 ☐ No filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) within 2 the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D35965 January 17, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Blaine Harding, 18111 Prince Philip Drive, #300, Olney, Maryland 20832 MD

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

= 2011

2401

32. Registrar's Signature

lesearch BLND Suite 330 MD

1 - For Amend Item 26 State of Maryland 1/Department of Death Mental Hygiene Reg. No.

1. Decedent's Name (First, Middle, Last) Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

MILLNER, CHRISTAL 177111

	Physici Medi		Christ	al D Mi	11ner					Month 01	0 7 Day	2011	2352 M
partie.	Exami		4a. Facility Name (i	if not institution, give	street and number)			4b. City, Town, c	r Location of D	eath		nty of Death	
750	<u> </u>		Suburba	n Hospita				Bethesd			Mont	gomer	У
ě	Funeral Director		5. Social Security N	791 ¹	ex	je (In <i>yr</i> s. li 52	ast birthday) Yrs.	If Under 1 Year Months Days			irth 9 1958 1958	9. Birth Cour	place (State or Foreign ntry) DC
	land show dat	for	Usual Residence o 10a. State	10b. County		10c. Cit	y, Town or Lo	cation				1	10d. Inside City Limits
	Mary 28a-f otifie	Je C	MD	Montgom	ery	Si1	ver Sp	ring					1 ¥ Yes 2 □ No
	a or be no		10e. Street and Nu	mber			-	10f. Zip Code			10g. Citizen c	of What Cou	ntry?
	h with	Funeral Director	2513 Mc	Veary Ct.	#D			2090	6		USA		
Baltimore, Maryland 21215-0036	e filed within 72 hours after death with the Maryland Ital Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	2	11. Marital Status 1 ፟፟፟፟ Mever Man 3 ☐ Widowed	ried 2 Married	12. Was Decedent Armed Forces? 1 Yes 2 X If Yes, Give			Vas Decedent of H f Yes, specify Cuba	an, Mexican, Pu	(Specify Yes or No lerto Rican, etc.)	В	ace - Americ lack, White,	etc.
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7	within giene. er tha				4)+ <i>)</i>	Unkno	wn			Unkno	wn	
nd	filed tal Hy d oth event	o Be	17. Father's Name (First, Middle, Last)	-			·	18. Mother's i	Name (First, Middle	, Maiden Surnai	ne)	
yla	ild be Meni iarke atic	6	Chester 1	Millner					Emma	Anderson			
Nar	of and 2 should be filed with of Health and Mental Hygien of Health and Mental Hygien fitem 27 is marked other the rother traumatic event, the		19a. Informant's Na	ame/Relationship (7)	pe, Print)		19b. Mailin	g Address (Street	and Number or	Rural Route Numb	er, City or Town,	State, Zip C	Code)
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יסר	ge 1 If it		1 🗆 Burial 2	Cremation 3	Removal from State	20b. P	lace of Dispo: emetery, crem	sition (Name of atory or other plac	· .	Date	20c. Location	-	
퍜	permit. Pa Departmer Important any injury	1.0		5 Other (Specif		Me	tropol	itan Cre	m. 01	/18/2011	Alexand	dria,	VA
Ba	permit. Page 1 Department of Important: If i any injury or o	l, i	21. Signature of Fu	peral Service Licens	ee	/				arshall-N			Home
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	Physician/ Medical		disease or condition resulting in death)		a. Due to (or as	te 1		rollar 1	In fem	Hon			Oliset and Death
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387	rtifica ing p e as t	/Me	IF FEMALE;										
	ne death certificate be executed the attending physician and ched for use as the burial-transit	ysicia	23b. Was decedent in the past 12 r 1	nonths?	23c. If yes, outcome of the line of the l	2 🗌 Fetal	death 3 🗌	Ectopic pregnanc Other (specify)	у		i	ate of delive onth	ery Day Year
<u>0</u>	The law requires that the atte has been signed by i page 2 should be detach	by Ph	Part II. Other signifi	icant conditions co	ntributing to death b	ut not resu	Iting in the ur	derlying cause giv	en in Part I.	23e. Did t	obacco use con	tribute to the	e cause of death?
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oro	v requ	Completed	11							24a. Was	an 24h.	Were auton	sy findings available
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<u>e</u>	sician: The la certificate ha lirector, page 2		25. Was case referre	d to medical				26. Pla	ace of Death (Ch	1 Yes	2 No	1 Yes	2 🗆 No
<u> </u>	lysici	10 E	examiner? 1 Yes 2	No F	lospital:	nt 2 2 E	R/Outpatient	0.11		Home 5 Resid	dance 6 17 Oth	or (Cassiful	
of	ng Pł ter th neral		27. Manner of Death	5 Pending	28a. Date of injur (Month, Day,	y 2	28b. Time of injury	28c. Injury	at		now injury occur		
on	eath. or: At the fu	iji Liga	2 Accident 3 Suicide	Investigation	(, 22),		,,	M 1 🗆	Yes 2 No				
Division of Vital Records,	To the Nospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	al Certificate:	4 Homicide	6 ☐ Could not be determined	28e. Place of Injurbuilding, etc.	(Specify)			- 17	City or Tow	· · · · ·		
:	the Hosp thin 24 ho the Fune mpleted fi	Med	only one) 3	Certifying Nurse	cian: To the best of r er: On the basis of ex Practioner: To the b	amination a	and/or investig	ath occurred at the	n, death occurre time, date and p	d at the time date a	and place, and di	in to the cour	actal and manner ates-d
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uis Ecuadoi IV	arar	1- For State Certificate of Death Reg. No.	01236
Physic Medical Exam			3. Time of Death 0816 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
Funeral		Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birth	place (State or
Director		Usual Residence of Decedent	ntry) Ecuador
w any		10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
faryland	Director	10e, Street end Number 10g, Citizen of What Count	
death with the Maryland ritems 23a or 28a-f she must be notified at once	al Dir		- L Con Pick
hours after death with the Maryland haural", or items 23a or 28a-fab	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Americ White, etc.	
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mand 2 should lealth and Mee tem 27 is man traumatic ev	욘		Zip Code)21001
		20a. Method of Disposition 20b. Place of Disposition (Name of cemeterly, Date of Cremation 3 Removal from State or Crematory or other place)	own, State
Baltimore permit. Pages 1 a Department of He Important: If its injury or other t		4 Donation 5 Other Specify: JRC MUUT 22 Name and Address of Facility	4 Boach
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart	Approximate Interval
Medical xaminer	ě n	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):	Between Onset and Death
	Ĺ	Sequentially list conditions,	
	Examine	if any, leading to immediate Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	
and and transit	al Ex	events resulting in death) Last Due to (or as a consequence of): d.	
60, ate be execut hysician and	ledic	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery	
x 687(n certifica ending pl	Physician/N	23b. Use of dealivery 23c. If yes, outcome of pregnancy 23c. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Date 4 Pregnant at time of death 5 Other (Specify)	ay Year
D. BO; the deatl by the att	Phys	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the	ne cause of death?
s, P.O. sires that the signed by	d by	Liver Disease, End Stage Renal Disease	ibly 4 🗹 Unknown
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tal Rection: The certificate ector, page			2 No
of Vital g Physician: fler this certif	o Be	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Ot	
ਵ ਵੱੂ ₹ ਵੋ	ion:	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred	
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Di the Hospital thin 24 hours a		1 29a, Certifier	1.
To the Hos within 24 h To the Fut completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated.	
	*	29b. Signature and title of certifier 29c. License number O.C.M.E. January 19, 2011	n, ∪ay, Year)
ϕ		30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell MD Assistant Medical Examiner 900 W Baltimore Street Baltimore MD 21223	
s	tate	Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Paer led (Month, Day, Year) 32. Registrar's Signature	
Regis		4.60 1 9 2 2 7 3 1 7 8 9	

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OCME

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Johna F Orter	1-For State Amend Item 5 per sa, 99 Certificate of Death Registrar Reg. No.							
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year	3. Time of Death 0540 hrs						
medicas Examiner	Lorna Porter January 8, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Dea							
French .	330 Central Avenue Hagerstown Washington							
Funeral Director	203 41 0025 15	irthplace (State or signCalifornia country)						
ku a	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits						
. .	MD Washington Hagerstown	1 Yes 2 No						
death with the Maryland or items 23a or 28a-f sho must be notified at once-uneral Director	10e. Street and Number 659 Hayes Avenue 10f. Zip Code 21740 USA USA	untry?						
er death with t	11. Marital Status 1 Never Married 2 Married 2 Married Forces? 1 Yes 2 No 3 Widowed 4 Noivorced If Yes, Give Year 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1 Yes 2 No Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Whole Specify: Speci	rican Indian, Black,						
urs afte	or Dates:							
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int. If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	Elementary/Secondary (0-12) College (1-4 or 5+) 1.2 2 during most of working life. DO NOT use retired)							
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than cevent, the Medica.		k						
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Baltimore, seenit. Pages l'ar semit. Pages l'ar separament of Hee important. Il itel injury or other tr	1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Nother Specify: in State							
Baltimo permit. Page Department o Important: injury or ott	21. Signal of Funeral Strice Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD	21201						
Physician Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failuce. List only one cause on each line.	Approximate Interval Between Onset and						
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D. BC truthe dest by the stacked for Physical	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to	o the cause of death?						
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Division of Vital Records, talor Attending Physician: The law requires rs after death. In Director: After this certificate has been signed in by the funeral director, page 2 should be striffication: To Be Completed	24a. Was an autopsy performed? 1 ✓ Yes 2 No 1 ✓ No 1							
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To the Hospi within 24 hou To the Funer completely fil	1/9a Centiler							
E SES	29b. Signature and title of certifier 29d. Date signed (M. January 12, 20d. Date signed (M. January							
	30. Name and address of person who completed cause of death (Item 23a)	-						
	Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223							
State Registrar								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 21: 44PM JANUARLY JOHNHIE 105 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BEHILD HOPKINS BATVIEW MEDICAL CENTER N/ABALTIMORUS 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Numbe **Funeral** (Month, Day, Min. 1 □ M 2 🙀 F 58 ukn Director Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County with the Maryland notified at Director MD N/A Baltimore 1 X Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be 1 PO Box 7123 21218 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black White etc. ģ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 XNo Baltimore, Maryland 21215-0036 SpecifyAmericasn 1 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed 4 Divorced Year or Dates Indian 16a. Decedent's Usual Occupation 16b Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Home Maker Home N/A Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Richard Lane Williams Dorothy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 7123 Baltimore, MD 21218 William Pace/Husband 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery crematory or other pla Final Journey 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/24/11 Woodbine, MD 22. Name and Address of Facility Charisse N. 21. Signature of Funeral Service Licensee Woods F/S 2700 Edmondson Ave. Balto., MD 21223 1 maila av 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest flock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final DISSEMINATED INTENVIOLEN COAGULATION Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 24 Hours SHUCK 21793C Sequentially list conditions. Examiner Due to for as a consequence on r any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 1 L Yes 2 L s t een signed by the 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has ; page 2 ☐ Yes 2 ☐ No certificate safer deam.
ral Director: After this ceruinal in by the funeral director, pr Be Was case referred to medical 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 Ø No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide 5 \square Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de To the Funeral Directo completed filled in by th 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 3 🗌 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 17,2011 M-D. -000 RUES 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 BATTERN AVENUE BALTIMORE, MD 21224 M. KARGRO CIMATH M-D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 24 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Physician/ 07AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death New Life Assistant Living Elkridge Howard 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 □ F Months February 28.1932 Maryland 215-28-4834 78 Yrs Director Usual Residence of Decedent 28a-f shov 10a. State 10b County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location with the Maryland 10d. Inside City Limits Director 1 Yes XX No Maryland Howard Elkridge 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6319 Old Washington Road United States 21075 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian rmed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify: 3 XWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker of Health and Mental Hygiens fitem 27 is marked other th Own Home 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert Gordon Byron Mary Saffran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shari Price/Daughter 6319 Old Washington Rd., Elkridge, Maryland, 21075 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date 1 ₩ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) meadowridge Memorial 1/22/2011 Elkridge, Maryland 7250 Washington Blvd., Elkridge, Maryland, 21075 21. Signature of Funeral Service Licensee 23a. Part Tenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequen / of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. E. let Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death Yes signed by the a d be detached f 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has by page 2 s autopsy certificate 2 🗆 No 1 Yes Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred After 1 Natural injury 5 Pending n 24 hours after death. le Funeral Director: Aft bleted filled in by the fur Yes 2 🗆 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined pleted filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the I

complet only one 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)
JAN 2 4 201

2. Registrar's

11-00483 Rog

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Roger Allen Pier		Sta 1-For State Registrar	te of Maryla		artment of ertificate of		d Mental F		eg. No. 211	0124
Physicia Medical Exami		Decedent's Name (First, Middle, Roger	Last) Alle	n	Pi	erson		2. Date of Dea Month January 1	_Day Year	3. Time of Death 1410 hrs
		 Facility Name (if not institution, 7410 Alvah Avenue, Ap 	•	nber)		4b. City, Town, or Dundalk	Location of Deal	th	4c. County of D Baltimore	
Funeral Director		216 42 2702	Sex	7. Age (In yrs.	last birthday) 68 Yrs	If Under 1 Year Months Days		n		Birthplace (State or oreign Country) Maryland
W any		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Locat					10d. Inside City Limits 1 Yes 2 X No
Maryland 28a-f show	rector	Maryland Balt 10e. Street and Number	imore		Du	ndalk 10f. Zip Code		1	0g. Citizen of What	
Baltimore, MD 21215-0036 pemit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	7410 Alvah Aven 11. Marital Status 1 Never Married 2 Marr	12. Was Dece Armed For	dent Ever in U		212 s Decedent of His es, specify Cuban			USA - 14. Race - A White, e	merican Indian, Black, tc.
urs after de tural", or i	百	3 Widowed 4 X Divord 15. Decedent's Education (Specific	If Yes, Give Year or Dates:	2 No	16a. Deceden	Yes 2 X No	on (Give kind of		Specify: \[\] 16b. Kind of Busine	White ess/Industry
1036 rithin 72 ho ene. r than "na fedical Ex	Completed	Elementary/Secondary (0-12) 12 years	College (1-			ost of working life. Lanance	DO NOT use re	tired)	Bethlehe	em Steel
MD 21215-0036 of 2 should be filed within 7 tht and Mental Hygiene. n 27 is marked other than numatic event, the Medica	Be	17. Father's Name (First, Middle, La Oliver Pierson					Kathryr	Gottscl		
MD 2 and 2 should alth and M m 27 is m	٩	19a. Informant's Name/Relationship Robert Pierson 20a. Method of Disposition	(Type, Print) Broth		711 E		ow Court	, Bel A	ir, Maryla 20c. Location - Cit	and 21014
Baltimore, permit. Pages I ar Department of Het important: If ite		1 Burial 2 X Cremation 4 Donation 5 Other Spec	cify:	m State	crematory or oth	rematory	21	nuary , 2011	Baltimore	e, Maryland
		21. Signature of Funeral Service Li	Law !	M0117	6 1/1	io sorrei	rs Point	. Road, 1	Dundalk,P Dundalk,M	J. 21222
Physician /Medical £xaminer		23a. Part / Enter the disease, or confailure. List only one cause or Immediate Cause (Final disease or condition resulting in death)	a. Atherosclero	otic Cardio	vascular Dis	_	such as cardiac	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset end Death
	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a of Due to (or a) Due to (or a							
ted to	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a od.	consequence	of):					
6 be executed visician and burial - transit	edical	UNPENDED	AMENDED							
of Vital Records, P.O. Box 6876 ing Physician: The law requires that the death certificate After this certificate has been signed by the attending phy uneral director, page 2 should be detached for use as the land.	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkno	1 Live bir	nt at time of de	2 Fel	al death 3 [ner (Specify)	Ectopic pregn	ancy	23d. Date of deli Month	very Day Year
	ā	Part II. Other significant condition	15 contributing to	death but not i	resulting in the u	nderlying cause gi	iven in Part I.			e to the cause of death? Probably 4 Unknown
Division of Vital Records, P.O. Box to a Attending Physician: The law requires that the death ra after death. al Director: After this certificate has been signed by the atter led in by the funeral director, page 2 should be detached for the control of the cont	Completed							24a. Was a autop perfor	sy prior med? deat	
Vital bysician: this certif	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 In	patient 2	ER/Outpatient		of Death (Check Other Nursi		Residence 6 🗸 0	ther: Scene
	ation: 1	27. Manner of Death 1 Natural 5 Pending 2 Accident Investig	g	f Injury Day,Year)	28b. Time of Ir		yatWork? es 2 No	28d. Describe h	now injury occurred	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could r 4 Homicide determine	not be 28e. Place	of Injury - At h	nome, farm, stree	t, factory, office bu	uilding, etc.	28f. Location (S or Town, S		Rural Route Number, City
To the Hos within 24 h To the Fur completely	edical	one) 2 Medicai Exami		examination a		ion, in my opinion,	death occurred		e(s) and manner as and place, and due t	o the cause(s)
	Σ	29b. Signature and title of certifier	1	/ > /	m)	29c. License O.C.N			January 18, 2	
//		 Name and address of person will Russell Alexander MD. 	Assistant Me	edical Exar	miner 900	W. Baltimore	Street, Baltir	nore, MD 212	223	
St Regist	ate rar	31. Date filed (Month, Aay) (04)	32. Reg	istrar s Signat	parket					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death JANUARY 2011 Physician/ 7:02 A M POLITZER CALVIN Ε Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE BRIGHTWOOD CENTER BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) . Age (In yrs. last birthday, **Funeral** Days 1**X** M 2 □ F Hours Min. 1471971922 88 Yrs MD 218-18-7068 Director Usual Residence of Decedent 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. iant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location Director notified 1 ☐ Yes 2 🙀 No BALTIMORE BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o edical Examiner must be Funeral 1 GRISTMILL COURT, UNIT 104 21208 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces' Black, White, etc. þ 1 Never Married 2 Married 1X Yes 2 □ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: If Yes, Give WW II Specify: WHITE Completed 3 X Widowed 4 Divorced Year or Dates er than "natur ; the Medical 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HARDWARE BUSINESSMAN is marked other aumatic event, th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည GOLDBERG DAVID POLITZER ELIZABETH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12515 MONTCLAIR DRIVE, SILVER SPRING, MD HOWARD POLITZER/SON oortant: If item 2 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State OWINGS MILLS, MD 1/21/2011 4 ☐ Donation 5 ☐ Other (Specify) HAR SINAI CEMETERY 22. Name and Address of Facility 21. Signature of Funeral Service Licen e SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final neumania Aspiration Physician, disease or condition resulting in death)) Medical as a consequence of Examiner myalgia oly Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last theresclavois Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 st performed 2 No 1 Yes funeral director, B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 No မူ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 DOA After this 27. Manny of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 5 Pending Natural 1 Yes 2 No ☐ Accident after death

Director: / Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours aft

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

parke

31. Date filed (Month, Day, Year)

24

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7505

32. Registrar's Signature

For State Registrar

State of Maryland / Department of Health and Mental Hygiene

0	Branch co.	2	2

Physician
/Medical
Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventing must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Registr

	Registrar	Cei	rtificate of Death	Reg	No.						
an al	1. Decedent's Name (First, Middle, Last) Dolly F Rampley		-	2. Date of Death January	Day 2011	3. Time of Death 1:30 A M					
er	4a. Facility Name (If not institution, give street and number 1922 Blacks Schoolhouse Ro		4b. City, Town, or Location of De Westminster	eath	4c. County of Death	irroll					
	5. Social Security Number 234-44-3635 6. Sex 1 M 2 DF 7. A. Usual Residence of Decedent	ge (In yrs. last birthday) 77 Yrs.	If Under 1 Year If Under 24 Hours N	Hrs. 8. Date of Birth (Month, Day, Month) 9/13/193	ea <i>r)</i> 9. Birthp Cour Wes	olace (State or Foreign ntry) st Virginia					
Be Completed by Funeral Director	10a. State 10b. County	10c. City, Town or Lo	cation		1	0d. Inside City Limits					
	MD Baltimore		Halethorpe			1 □Yes 2 📉 No					
ral Dir	10e. Street and Number 1901 NortheastAvenue		10f. Zip Code 21227	10g	. Citizen of What Cour USA	ntry?					
ne	11. Marital Status 12. Was Decedent Armed Forces'	Ever in U.S. 13.	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No-	14. Race - Americ						
by Fu	1 □ Never Married 2 □ Married 1 □ Yes 2 □ If Yes, Give Year or Dates:	No !	1 □ Yes 2 No Specify:	derio Ficari, etc.)	Black, White, Specify: Wh	etc. nite					
ted	15. Decedent's Education	16a. Dece	dent's Usual Occupation	16	b. Kind of Business/In	dustry					
Comple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	5+) (Give life. I	kind of work done during most of DO NOT use retired) Homemaker	working	Own Hon	ne					
To Be (17. Father's Name (First, Middle, Last) James B. Patrick Hedrick		18. Mother's f	Name <i>(First, Middle, Ma</i> Argie Blan	iden Surname) ich Wilfor	ıg					
9	19a. Informant's Name/Relationship (Type. Print) Allen Stottlemire, Sr - Sc	I	ng Address <i>(Street and Number of</i> 5 Hightimber Dr.			,					
	20a. Method of Disposition	20b. Place of Dispo	sition (Name of matory or other place)	Date 20	c. Location - City or To	own, State					
	1 XX urial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		ige Memorial Par	k 1/11/11	Elkridge.	Maryland					
	21. Signature of Funeral Service Licensee		2. Name and Address of Facility			Tar y zama					
	I Chalith Da	// Ga	ary L. Kaufman F	uneral Home	at MMP, I	at MMP, Inc.					
	23a. Part 1. Enter/ the disease, or complications that covered the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, oximate										
l k	Shock, or art tallure. List only one cause on the sine. Immediate Cause (Final Const and Death Const and Deat										
8	disease or condition resulting in death) a. Curchary A-tery Uisiase Hours										
	Due to (or as a consequence of):										
<u>_</u>	Sequentially list conditions,										
amine	Sequentially list conditions of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.										
n/Medical Examiner	resulting in death) Last Due to (or as a consequence of): d										
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ysician/I		2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year						
Ph	Part II. Other significant conditions contributing to death	out not resulting in the u	nderlying cause given in Part !	23e. Did tobar	cco use contribute to t	he cause of death?					
by	Hype-tension	out not rooming in the o	ndonying cadde given in raski.		□ Yes 2 □ 100 3 □ Probably 4 □ Unknown						
tec					2 10 0 110	oably 4 Olikilowii					
omple	Obstruction She p Apr			24a. Was an autopsy performe 1 □Yes 2 5	d? prior to co	opsy findings available impletion of cause of					
e C	25. Was case referred to medical		26. Place of	Death (Check only one)							
0	examiner? 1 Yes 2 No Hospital: 1 Inpat	ient 2 ER/Outpatier	nt 3 DOA Other: 4 Nursin	ng Home 5 ☐ Residend	ce 6 Other (Speci	Daughlers (forder					
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ertifica	3 Suicide 6 Could not be 28e. Place of Ir	jury - At home, farm, str tc. (Specify)		28f. Location (Stre City or Town,	et and Number or Run State)	al Route Number,					
Medical Certification: To Be Completed by Physicia	29a. Certifier (Check only one) 1 Certifying Physician: To the besis and manners and manners	of examination and/or ir	h occurred at the time, date and p evestigation, in my opinion, death of	lace, and due to the cau occurred at the time, dat	ue to the cause(s) and manner as stated. the time, date and place, and due to the cause(s)						
Me	29b. Signature and title of certifier		29c. License number	290	I. Date signed (Month,	Day, Year)					
	Mh		051811	01	119/2011						
	30. Name and address of person who completed cause of Thomas Chiera 1120 No	A (*	Print) Rd By Hines,	MD 2/22	8						
te		trar's Signature									
ar	Unit & = 2011 Clever 13.	garre									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend #2&5 Per Phy &FH G911 1/31/2011 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Gilbert Physician/ Month Year Rosenberger Tanuar 10:20 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death Seasons Hospice Randalstown Baltimore 5. Social Security (1998) 212 14 5981 If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. June 19, 1921 7. Age (In vrs. last birthdav) 9. Birthplace (State or Foreign **Funeral** 1 ★ M 2 □ F 89 Yrs Mary Tand **Director** Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10b. County 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.
27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Arbutus 1 Yes 2 No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 919 Calwell Road 21229 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2X Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Year or Dates. Army 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use gettired)
Mechanic 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Automotive Ò Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles Rosenberger Florence Engleman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other tra Loretta Rosenberger / Wife 919 Calwell Road, Baltimore, Maryland, 21229 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Meadowridge Memorial TYP Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1/24/2011 Elkridge, Maryland 21. Signat re f Funeral Service License 22. Name and Address of Facility Gary L. Kaufman Funeral Home, Inc. 7250 Washington Blvd,Elkridge,Maryland 21075 23a. Part 1. Enter the disease, or complications that caused the ceath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End-Stage Renal Disease Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral inverted infector, page 2 should be detached for use as the burial-transit signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown this certificate has been s ral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 🗌 No 1 🗌 Yes Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) Hospital: 2 1 No ြု Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MSKajapakse M.O DOU57465 1/20/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -Baltimore, MD. 21209 N.S. Rajapakse, M.D. 2835 Smith A V. 5-703 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 4 20 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** P^{M} 2011 7:33 S. Ragland January Fay /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Carriage Hill of Bethesda Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 21, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🔀 F 78 1932 579-42-5919 May Maryland Director Usual Residence of Decedent 10d. Inside City Limits 72 hours after death with the Marylanc 10c. City, Town or Location 10b. County 10a. State ? Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evantary, ust be notified at 1 ☐ Yes 2 🔀 No Director Bethesda Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9501 Montgomery Drive 20814 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🛣 No Specify. Specify: White δ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Insurance Executive Insurance 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy Important: If item 27 is marked othany injury or other traumatic event 17. Father's Name (First, Middle, Last) Be Arkley Howard Salter Lucille Marie Benton ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rebecca Lynn Fitzke /Niece 7409 Pickhurst Court, Matoaca, Virginia 23803 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition January 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. 20, 2011 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. properties male 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 Approximate Interval Between Onset and Death 23a. Part 1. Exper the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, wheart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 3 to 4 days **Physician** Aspiration Pneumonia " /Medical Due to (or as a consequence of): Examiner Dysphagia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 🖾 No 4 Pregnant at time of death 5 ☐ Other (specify) signed by the and be detached f P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Cerebral Neurological Syndrome of Unknown Etiology 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 2 X No certificate 1 ☐Yes 2 ☐No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 🕅 Nursing Home 5 🗌 Residence 6 🗎 Other (Specify) 1 ☐ Yes 2 🛣 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral c 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) 1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year) JAN 24 2011



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

D35579

January 19, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Januar 1 Physician/ 754 PM Mayzetta Sutherlin 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Cit Hospital Kaltimore If Under 1 Year If Under 24 Hr 8. Date of Birth (Month, Day, Year) Sept 12, 1914 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏻 F Hours Virginia Director 96 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director Suther lin Mayze Ha Baltimore 1 Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a or edical Examiner must be Funeral USA 21217 1356 N. Calhoun St. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian 11. Marital Status Black, White, etc. ð 1 Never Married 2 Married 21215-0036 black 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Department of Health and Mental Hygiene. Important: If item 27 is marked other thany jiury or other traumatic event, the N hospitality domestic worker unk unk Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Margaret Robinson Richard Webster Sutherlin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 524 N. Charles St Apt 711; Baltimore, MD 21202 Louise Tapper - niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) In State permit. Page 1 22. Name and Address of Facility State Anatomy Board Signature of Euneral Service Licensee 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Cerebro vascular disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter orderlying Cause (Disease or iinjury Examine Due to (or as a consequence of) physician and the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown g Unknown Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 1 ☐ Yes 2 No this certificate 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ■Inpatient 2 □ ER/Outpatient 3 □ DOA မှ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After work?
1 Yes 5 Pending 2 Accident
3 Suicide Investigation within 24 hours after death To the Funeral Director: completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title 282 63 lero ML)anuany 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Valero Sinai 32. Registrar's gnature State Registrar

			Amend 19a, per	i se Type or Pri AB G912 2 State of M	nt in Bla 2/11 TT aryland/	ck Ind	lelible In	k. Ensur	e All Copie	es Are	Legible	ə.	1246
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	Diversials	/	1. Decedent's Name (First, Middle	, Last)					2. Date of D	eath			ime of Death
	Physicia Medic		Emily Ruth St						Month O/	Da //	y Year 26/1	9	733/PM
	Examir	ner	4a. Facility Name (if not institution,	give street and number)		41	b. City, Town, or	Location of De	eath	4c.	. County of De		
7	Funeral	r	TENINSUIA KEG 5. Social Security Number	6. Sex 7. Ag	e (In yrs. last bi	irthday)	f Under 1 Year	If Under 24	irs. 8. Date of B	irth	HICO		State or Fernian
	Director	ı	313-34-4616	1 □ M 2 🖺 F	80		onths Days		in. Sept 2	ay, Year)	930 Ma	Country) Lrylar	State o <i>r Foreign</i> 1 d
	h ow	L	Usual Residence of Decedent 10a, State 10b, County		10 01 7								
	Marylan 18a-f sh tified a	recto	MD Wico	mico	10c. City, Tov	sbury	on						side City Limits ☐ Yes 2 No
	with the I s 23a or 2 ust be no	Funeral Director						tizen of What (Country?				
9200	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Health and Mental Hygiene. This marked other than "hatural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:					(Specify Yes or No erto Rican, etc.)		14. Race - Am Black, Wh Specify: Wh	ite, etc.	ian,	
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and	be filed lental Hy rked oth ic event	To Be	17. Father's Name (First, Middle, L Adolf John St	· ·					Name (First, Middle Myrtle				
ary	2 should lith and Me 27 is marl r traumati		19a. Informant's Name/Relationsh Stiemke	ip (Type, Print)	19	b. Mailing A	ddress (Street a		Rural Route Numb			Zip Code)	
	and 2 s Health tem 27		Jean Stienke - s	sister-in-la	w	3703	Trinity	Ct; As	sheville,	Nort	th Card	lina	28805
Baltimore,	ge 1 a nt of H : If ite or oth		20a. Method of Disposition 1	3 Removal from State	20b. Place cemet	of Disposition of Dis	on (Name of ory or other plac	e)	Date	20c. Lc	ocation - City o	or Town, Sta	ate
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Ba	Department of the concession o	18	21. Signature of Funeral Servici Li R.Onald. 8	gen walk / Vise	grør				e St; Bal			2120	1
d			23a. Part 1 Enter the disease, or o shock, or heart failure. List or	complications that caused	the death. Do	not enter th	e mode of dying	g, such as cardi	iac or respiratory a	rrest,			ximate
~.P	h sician/	(2. 3)	Immediate Cause (Final disease or con	ny one cause on each line		ASWI	·						al Between t and Death
1	Medical Examiner		resulting in death)	Due to (or as a								245	urs .
		er	Sequentially list conditions,	b. — Tale b. Const.	rori seguanos	SAFE S						-	
7	d ansit	Examiner	If any leading to immediate cause. Enter Underlying Cause (Disease or linjury	200 10 101 20 2	. consequence	Oty.							
	executed an and rial-transit		that initiated events resulting in death) Last	Due to (or as a	consequence	of):							
99	the bu	dica	•	d									
200	tri cerilicate be ex-	/Me	IF FEMALE:	23c. If yes, outcome of	of pregnancy	-				T			
Box 68760	9 9 8	by Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live Birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗀 Fetal deat		topic pregnancy her (specify)				23d. Date of d Month	elivery Day	Year
О. ‡	been signed by the should be detached	y Ph	Part II. Other significant condition	ns contributing to death bu	ut not resulting	in the under	rlying cause give	en in Part I.	23e. Did 1	tobacco us	se contribute t	o the caus	e of death?
JS,	n sign uld be								_ 1 🗆	Yes 2	√ No 3□	Probably	4 🗆 Unknown
Vital Records,	is bee	Completed							24a. Was				lings available
ž ž	ate ha	Som							auto	psy ormed? 2 No	death?	es 2 \square N	n of cause of
tal	sertific sector,	Be	25. Was case referred to medical examiner?	Hospital:				ce of Death (Ch				-	
	this c	2	1 Yes 2 No 27. Manner of Death	28a. Date of injur	nt 2 ER/O	utpatient 3		4 ☐ Nursing	Home 5 Resi			cify)	
בו קונים	th. After	cate	1 Natural 5 Pending 2 Accident Investiga	(Month, Day,		injury	28c. Injury work? VI 1 1		28d. Describe	how injury	occurred		
DIVISION OF	er dea ector by the	Certificate:	3 Suicide 6 Could n 4 Homicide determin	ot be 28e. Place of Injur				765 2 110	28f. Location (Number or Ri	ural Route I	Number,
בַּ בַּ	urs aft			building, etc.					City or Tov	,			
Hosp	Fune Fune eted fi	Medical	(Uneck 2 L Medical Ex	Physician: To the best of raminer: On the basis of ex	amination and/	or investidati	on, in my opinior	 death occurre 	d at the time, date a	and place.	and due to the	cause(s) ar	nd manner stated.
DIVISION OF VITAL RECORDS, P.O. In the Hosnital or Attending Physician: The law requires that the	within 24 hours after death, To the Funeral Director After this certificate has is completed filled in by the funeral director, page 2		only one) 3 ☐ Certifying I 29b. Signature and title of certifier	Nurse Practioner: To the b	est of my know	riedge, de <i>a</i> th	29c. License	time, date and p	place, and due to the	ne cause(s)	and manner a	s stated.	
			> mte mel	Davus	SHA NAT	ESTN	005		i		nuary		
			30. Name and address of person w	ho completed cause of de	ath (Item 23a) i	(Type, Print)						- /	
			DR: USHA NATE 31. Date filed (Month, Day, Year)	SAN, 1415	· 5. D /	5/5/0 N	IST, S	ALISBU	RY, MD	218	04		
	State Registra	_	JAN 2 4 20	11 Security	's Signature	back	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#3perPHYS, G912, 2/7/2011 WS

Amend Item 26 Per Verby, g91/1,01721/2011 drib

Amend Item 26 Per Verby, g91/1,01721/2011 drib 1 - For A State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 7. Til 8 of Amth January Physician/ 13 2011 Charles L. Storrs Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carroll If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign China **Funeral** Month, Day, Year) 10/25/1925 1 ℃ M 2 □ F 032-20-4832 85 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Md Carrol1 Sykesville 1 ☐ Yes 2 ¥ No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 7200 Third Ave 21784 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11 Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business Industry life. DO NOT use retired) Elementary/Seconday (0-12) Physicist Physicist (PHD) Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Charles L. Storrs Mary M. Goodwin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty L. Storrs (Wife) 7200 Third Ave Sykesville, Md. 21784. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 D Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 01/14/2011 Sykesville, Md. ^{22. Name and Address of Facility} Haight Funeral Home & Chapel P.O. Box 195 Sykesville,Md. 21784. 21. Signature of Funeral Service License W ans 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preynowia HSPIRA how Physician/ moulh disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Cerebrounswar المدينة بمارا Accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical $\#Aa_{0}$ Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 1 certificate 2 No 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) this within 24 hours a er death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 13/2011 (-gailor Tu D3(660 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WESTMINSTER 5 TONER Avenue moucher GALVIN THOMAS K 31. Date filed (Month, Day, Year)
JAN 2 4 2. Registrar's Signature State 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 10:00AM Medical JANUARY 2011 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death GLEN BURN ALTIMORE WASHINGTON MEDICAL RNNE ARUNDEL If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Hours Month, Day, Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits, 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral 1583 1.5. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☑ Yes 2 ☑ No Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced HITE 15 Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) ONSTRUCTION DINTER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ည Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) Department of Health and Important: If item 27 is m 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TERESA BROWN, DAI Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State remetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State any injury or 4 Donation 5 Other (Specify) -14-11 ODENTON. permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DAUGHERTY FUNERAL HOME M00942 21a. Part 1. Enter the disease, or complicated mill caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PNEUMONIA disease or condition resulting in death) WIEEK Medical Due to (or as a consequence of): Examiner RENAL FAILURE 20A45 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-trar that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be execu Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown HYPERTENSION 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed? death? 2 🗷 No 1 Yes 2 No Be 25. Was case referred to medical funeral director 26. Place of Death (Check only one) ည 1 Yes 2 No 1 Nation 1 DOA Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending Accident 2 No Investigation 24 hours after death Funeral Director: Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 within 2 To the I only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D0061832 JANUARY 13

DHMH 17 Rev 7/2009

Registrar

HOSPITAL DRIVE, GLENBURNIE, MD 21061

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAMIR K.
31. Date filed (Month, Day, Year)

301

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav **Physician** Francis 20 02:20A 2011 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs.

Months | Davs | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Days Hours 212-36-1758 73 2-3-1937 West Director VA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at 1 X Yes 2 □ No Director MD na Baltimore 10e. Street and Numbe 10f. Zip-Code 10g. Citizen of What Country? 23a or 6519 Rosemont Avenue 21206 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 💢 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2X No Specify: 9 Specify: Black 3 XWidowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.
is marked other than "natural"
aumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Brager Gutmans 12th grade <u>Sales Associate</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Harcum Natalie Twyman ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Clifton Sutton-Son 6519 Rosemont Avenue Balto, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) 1-25-2011 Glen Burnie, Cedar Hill Cem 21. Signature of Funeral Service License 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, 21202 23a. Part 1. Inter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** STYCKE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 9:20 OF Sequentially list conditions Examiner il any, leading to immediate cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Live birth 2 Fetal death Ectopic pregnancy 4 Pregnant at time of death Month Year Day 5 Other (specify) signed by the at 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 TYes No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has builtautopsy 1 ☐ Yes 2 ☐ No Yes the Hospital or Attending Physician: 25. Was case referred to medical director, Be 26. Place of Death (Check only one examiner? Other: 4 \sum Nursing Home 1 Yes 2 No 2 ER/Outpatient 3 DOA Inpatient 5 Residence 6 Other (Specify) မ After this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Natural 2 Accident death. 1 Yes 2 No after death filled in by the 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 hot To the Funel completely fi (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one)

State

Pah 31. Date filed (Month, Day, Year) 2 4

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

DHMH 17 Rev 1/200

Registrar

29c. License number

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

12011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Keith Joseph Soskin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph 8. Date of Birth
Dec • 20 , 1971 If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral Ӂ**҈**Х**м 2 □ F Days Hours 39 North Dakota Director 219-06-1511 Usual Residence of Decedent 10a, State 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director "natural", or items 23a or 28a-f s Owings Mills 1 Yes XXNo Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21117 U.S.A. 11108 Wild Branch Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes XX No Black, White, etc. by 1 Never Married XIX Married 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give 3 Widowed 4 Divorced Specify: White Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Vice President Education and Mental Hygien is marked other the Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Diane Lynn Hizer Soskin A7an and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Soskin / Father Roaches Lane, Reisterstown, MD 21136 Alan Department of Health Important: If item 27 any injury or other to once. 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Druid Ridge XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1/25/11 Pikesville, MD Cemetery 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of F 11605 Reisterstown Rd. Owings Mills, MD21111 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Non-Small-Cell disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for an a compaquence of Hospital or Attending Physician; The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Dav Year 5 Other (specify) Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has perform certificate 2 No 1 Tes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natura. Accident 5 Pending 1 🗌 Yes 2 🗌 No Investigation Could not be 3 ☐ Suicide 4 ☐ Homicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined within 24 hours after To the Funeral Dire Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ George John Shukis January 18 2011 10:00 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Gilchrist Hospice Baltimore Towson Social Security Number **Funeral** 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 1 🗓 M 2 🗆 F Months Days Hours Min 03-07-1922 042-12-2763 Director 88 Connecticut Usual Residence of Decedent ms 23a or 28a-f show must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Maryland Howard Columbia 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6500 Freetown Road 21044 U.S.A. ural", or items a 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 X Yes 2 No 1 ☐ Yes 2 K No Specify. "natural", If Yes, Give 3 Widowed 4 X Divorced Specify White Year or Dates other traumatic event, the Medical 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working of Health and Mental Hygiene. Item 27 is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Tool and Dye Worker Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Peter Shukis Mary (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debbie Barrow (Daughter) 6123 Lori Lane Elkridge, Maryland 21075 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot 20c. Location - City or Town, State 1 ★ Burial 2 ☐ Cremation 3 ★ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, injury or State Veterans Cem 1-24-2011 Middletown, CT 21. Signature Funeral Service Lice 22. Name and Address of Facility 22. Name and Address of Facility Witzke Funeral Homes, 5555 Twin Knolls Road Columbia, MD 23a. Pair 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition resulting in death) Due to (or as a consequence of) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Phystcian: The law requires that the death certificate be executed Cause (Disease or finjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed? Yes 2 No After this certificate 1 Yes 2 No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? 2 **X**No 1 🗌 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Matural 5 Pending injury 1 Yes 2 No □ Accident Investigation filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide within 24 hours a Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and of certifier 29c, License number 18

State Registrar AMON

31. Date filed (Month, Day, Year)

JAN 2 4 2011

6701

100

32. Registra 's Signature

N. Charles

TOWSON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHANKES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Voa Physician/ :23 AM Medical Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Maryand Medical Center Hyore of 9. Birthplace (State or Foreign Country) West Virginia . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral (Month, Day, Year) 12/13/1940 1 🛛 M 2 🗆 F Hours Director 234-64-3588 Usual Residence of Decedent or 28a-f show notified at show 10d. Inside City Limits 10a. State 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Frederick Monrovia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be n ò Funeral U.S.A. 21770 4936-A Green Valley Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status "natural", or iter Armed Forces?
1

Yes 2 □ No Black, White, etc. ģ 1 Never Married 2 K Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Completed 3 Widowed 4 Divorced Year or Dates White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Education Artist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ t. Page 1 and 2 should be frrment of Health and Menta rtant: If item 27 is marked njury or other traumatic en Handlev Shobe Annie Charles Breathed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tr 4936-A Green Valley Road, Monrovia, MD 21770 Susan M. Delaney / Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Anatomy Gifts Registry 01/21/2011 Hanover, Maryland 21. Signature of Fineral Servic Licensee 22. Name and Address of Facility Anatomy Gifts Registry MD 21076 7522 Connelley Dr., Ste. P, Hanover, 23a. Part 1. Enter the diseas or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Gran Negative Physician Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of Prostate Cancer attending physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No ō Month 4 Pregnant a Pregnant at time of death 5 Other (specify) signed by the at d be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ✔ Unknown Records, Jeutoperia Completed should Squamous cell carcinoma 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has page 2 s autopsy performed? Yes 2 No death?
1 Yes 2 No certificate 25. Was case referred to medical Division of Vital Hospital or Attending Physician: 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 No ၉ 1. Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) funeral 28c. Injury at work? 1 ☐ Yes 2 ☐ No Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: After injury 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 within 2. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0063595 16,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) + Baltmore, MO Kathyn 22 She

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

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32.

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January Robert Bruce Stenstrom 19, 2011 9:29 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery Hospice Casey House Rockville Montgomery Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** March 7 1 X M 2 □ Months Days Hours Min Year 935 531-32-6755 75 **Director** Oregon Usual Residence of Decedent Show 10a, State 10b. County within 72 hours after death with the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f sl notified 1 Yes 2 X No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral 7000 Richard Drive 20817 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? 1962-Black, White, etc. ģ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify. 1967 3 Widowed 4 Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working U.S. Customs life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Border Control 5+ Project Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental He filed of Health and Mental He filem 27 is marked ot rother traumatic ever Joseph Francis Stenstrom Agnes Catherine Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a Joe Ann Stenstrom / Wife 7000 Richard Drive, Bethesda, Maryland 20817 Page 1 and 2 Baltimore, 20b. Place of Disposition (Name of Monte Omery) or other place)
Crematorium, Inc. 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 🔀 Cremation 3 D Removal from State January 21 permit. Page Department of Important: If any injury or Bethesda, Maryland 4 Donation 5 Other (Specify) 2011 Signature of Fun va Servi e Liansee Robert A. Aftenson Facility Funeral Home/Bethesda-Chevy Chase. mette M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Years Immediate Cause (Final Ph_sician/ Malignant Melanoma with Metastases Medical resulting in death) Due to (or as a consequence of ್ Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of signed by the attending physician and d be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 4 Pregnant 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has all director, page 2 autopsy performe 2 \square No 1 Tes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\mathbb{X} \) Other (Specify) 읻 1 ☐ Yes 2 🛣 No Hopsice 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 🖾 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation s after death filled in by the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital within 24 hours a Medical 29a. Certifier 🛆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie D37142 1-19-2011

Registrar

DHMH 17 Rev 7/2009

State

1355 Piccard Drive, Suite 100, Rockville, Maryland 20850

30. Name and actiress of person who completed cause of death (Item 23a) (Type, Print)

Coleman, MD 31. Date filed (Month, Day, Year)

JAN 24

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ AMUEL JANUARY 20^{'ear}1 4:13 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE ARDEN COURTS BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) 1 🛛 M 2 🗆 F Min 0371671954 220-48-3361 56 Director Yrs. MDUsual Residence of Decedent or 28a-f shov 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 ☐ Yes 2XX No MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 12613 WATERSPOUT COURT 21117 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2 XXMarried ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural" Completed 3 Divorced Specify: WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) CERTIFIED PUBLIC ACCOUNTANT ACCOUNTING Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SIGMUND SNYDER ELSIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY JANE SNYDER/WIFE 12613 WATERSPOUT COURT, OWINGS MILLS, MD 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1XXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BALTIMORE HEBREW CEM: 01/21/2011 REISTERSTOWN, MD Shinalure of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line FRUNTU Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopo, performed death? 1 Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Urrsing Home 5 Residence 6 Other (Specify) 2 **O**No 1 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No 24 hours after death Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

Registrar DHMH 17 Rev 7/2009

State

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Gaber MD

29b. Signature and title of certifie

30. Name and address of

JAN 24

31. Date filed (Month, Day, Year,

Jeffra

Greenetree

rson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

1838

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year)

Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First_Middle_Last) 2. Date of Death 3. Time of Death Physician/ January 18, 201^{Year} 5:40 A M Harriet Elizabeth Tarzwell Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Gaithersburg Montgomery Wilson Health Care Center 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Hours Min. (Month, Day, Year, 1 🗆 M 2 💢 F Director 87 Michigan 363-22-4507 4 1924 January Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4 Steeple Court 20874 United States should be filed within 72 hours after death and Mental Hygiene.

is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black. White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 X Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Salesperson Retail permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Elizabeth Jones George A. Morrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scott R. Tarzwell / Son 20874 Steeple Court, Germantown, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State January 24, cemetery, crematory or other place) Inc 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 2011 Montgomery Crematorium, Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home / Rockville, Inc. 21. Signature of Funeral Service Licensee 1 M01596 300 West Montgomery Avenue, Rockville, MD 20850 23a. Part 1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) e van 07110 Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury ance that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown been signal Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy his certificate hil director, page performe 1 Yes 2 No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 X Yes Other: 2 🗌 No မ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) funeral Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1. Natural 2 Accident 3 Suicide 5 Pending 1 Yes 2 No Unt within 24 hours after death

To the Funeral Director: /
completed filled in by the f Investigation Could not be -a // Dec 52,200 28f. Location (Street and Number or Rural Route Number City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 10 mg Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

State

29a. Certifier

(Check

only one)

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31. Date filed (Month, Day, Year,

UE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

MOOME

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Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 195011 Physician/ Month 20/1 Medical 4a. Facility Name (if not institution, give effect and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore City N/A5. Social Security Number 8. Date of Birth
1 - 1 7 - 1 9 4 4 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Hours Months Min. Maryland 67 Director 217**-**40-8318 Usual Residence of Decedent 3a or 28a-f show be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Harford Co. Edgewood 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral Examiner must 3330 Willoughby Beach Road 21040 USA items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. 2 1 Never Married 2 Married 72 hours after ģ 1 ☐ Yes 2 🛛 No Baltimore, Maryland 21215-0036 Specify: White 1 Tes 2 No If Yes, Give Specify "natural", 3 🕅 Widowed 4 🗆 Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Schould be filed within 72 l h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 10 N/A Bartender <u>Hospitality</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (UNK) မ Mathew Brookman permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cindy Raab- Daughter Willoughby Road Edgewood, MD 21040 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 1-20-2011 Baltimore, MD 22. Name and Address of Facility Kaczorowski Funeral Home, PA 1201 Dundalk Avenue Baltimore, MD 21222 -Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ disease or condition resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying sician and burial-transit Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) 1 Yes 2 Unknown ed by the a 9 Unknown Division of Vital Records, P.O. signed by be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part !. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death?

1 Yes 2 No has page 2 autopsy 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☐ 1√0 မ 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural iniury work? 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fi 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed gause of death (Item 230) (Type, Print)

H Chrof Calo Color of Marian FUCS OS land 1 ive Son to Dest Tours on 40 2120 61

Registrar

State

31. Date filed (Month, Day, Year)

JAN 24

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 2 0 1 1 January 5:29 pM Ellianne Lilly Westbrook-Turner /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Greater Baltimore Medical Towson Baltimore Ctr Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 🗓 F 3 MD 1/11/2011 Director None Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2√ No Directo Randallstown MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21133 USA 9906 Southall Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify. 3 Widowed 4 Divorced "natural", er than "natura" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Health and Mental Hygiene. Infant Infant 0 Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Danielle Nicole Westbrook Duwane Carnell Turner 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health a
Important: If Item 27 Is
any Injury or other trau 9906 Southall Road; Randallstown, MD 21133 Danielle Westbrook - mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 NOther (Specify)in state 22. Name and Address of Facility State Anatomy Board 21. Sign was Funeral Sprice Licensee Director 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between 23a. Onset and Death Immedite Cause (Final disease or indition resulting in death) Physician Extreme Prematurity /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) the detached 9 Unknown 9 ☐ Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 🔀 No 1 □ Yes 21√2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death

To the Funeral Director:,
completely filled in by the f 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 3227 Falls Road Cockeysville, Md 21030 Fareeda N. Rizvi

State Registrar 31. Date filed (Month, Day, Year) JAN 2 4 2011

2. Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death dent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs 8 Date of Birth Birthplace (State or Foreign Country)
 MD Funeral ZM 2□F Min 04-21-1932 MD Director 216-30-8219 78 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2X No Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21050 USA 1312 Sharon Acres Rd 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify Specify: White "natural", 3 Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the N 12 General Manager Undercoating Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George J. Winkler Mary M. Carmine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1312 Sharon Acres Rd Forest Hill, MD 21050 Dolyres G. Winkler (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 01-17-2011 Bayview Crematory Baltimore, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of BelAir 610 W. MacPhail Rd BelAir, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying for use as the burial-transit Jause (Disease or linjury attending physician and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death Yes 2 No s been signed by the sahould be detached a Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 After this certificate has autonsy Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? မ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES-000 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue Baltimore MWAK INGWE AGNES M.D MD. 21224 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

yan

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 3:35A M **Physician** anuary 12 201 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5-30-1947 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ₹M 2 □ F 212-48-5463 63 MD Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10h Counts ral", or items 23a or 28a-f show Examiner must be notified at XXYes 2 □ No Director MD na Baltimore with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 2901 Orleans Street USA 21224 Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Race - American Indian, Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Black Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical Baltimore City Elementary/Secondary (0-12) College (1-4 or 5+) other than 12th grade Sanitation Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be n and Mental F Joseph Ward Mercedes Taylor မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 754 Barlett Avenue Balto, MD 21218 <u>Crystal Ward</u> -Daughter
20a. Metriod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 1/24/2011 Balto,MD 4 ☐ Donation 5 ☐ Other (Specify) Greenmount 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or s a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or as a consequence of attending physician and for use as the burial-transit Cance metastatic Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No the 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has perform 1 ☐ Yes 2 ☐ No Yes certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 🗆 DOA မ this completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury I or Attending P safter death. | Director: After t Medical Certification: 5 Pending investigation 1 Natural (Month, Day Year) Injury 1 Yes 2 🗌 No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier one) and manner stated To the within 2 To the 1 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature-and title of certifier RES-000 January

State Registrar

DHMH 17 Rev 1/2001

Registrar's Signature

600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sonhi

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			i to gioti di	artment of Health and Mer rtificate of Death	ntal Hygiene	01260
	Dhusisis	-/	Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year 3. Time of Death		
and the second	Physicia Medic		Katherine Ruth Warehime		January 12, 201	1 9:40 A.M
	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death Westminster	4c. County of De	
			Dove House 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)			Sirthplace (State or Foreign
	Funeral Director		215-20-7688 1 M 2XXF 89 Yrs.		(Month, Day Year) pr. 19, 1921 Wes	Scountry) St Virginia
	M.		Usual Residence of Decedent		· · · · · · · · · · · · · · · · · · ·	
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	cto	10a. State 10b. County 10c. City, Town or L			10d. Inside City Limits
		Director	Maryland Carroll Mano	hester 10f. Zip Code	40 000 -6300 -4	1 Yes 2XXNo
		la La		· ·	10g. Citizen of What C United S	States
		Funeral	P.O. Box 162 11. Marital Status 12. Was Decedent Ever in U.S. 13	21102 Was Decedent of Hispanic Origin? (Specify	Yes or No- 14. Race - An	LCa nerican Indian,
9	or its	by F	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 XXNo	If Yes, specify Cuban, Mexican, Puerto Rica 1 Yes No Specify:	an, etc.) Black, Wh	
93	ırs aft ural", I Exal	je je	3XXWidowed 4 □ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 ☑ No Specify:	Specify: W	nite
5-(72 hou	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation kind of work done during most of working	16b. Kind of Busines	s Industry
12	ithin 7 ene. • than	Son	Elementary/Seconday (0-12) College (1-4 or 5+)	oo not use retired) Assembly Worker	Black 8	& Decker
d 2	Hygiw Hygiw other ent, t	Be (8th 17. Father's Name (First, Middle, Last)		irst, Middle, Maiden Surname)	
Maryland 21215-0036	l be fi fental rked tic ev	မ	Lannie Grover Harper	Carrie S	mith	
ary	hould and M is ma	7.0	19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ing Address (Street and Number or Rural Ro	oute Number, City or Town, State, 2	Zip Code)
Σ	permit. Page 1 and 2 s Department of Health s Important: If item 27 i any injury or other tra once.			Rinehart Road, Wes	tmisnter, Maryla	and 21158
Baltimore,			20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, cre	osition (Name of Date matory or other place) Jan •	20c. Location - City o	or Town, State
Ħ.			4 □ Donation 5 □ Other (Specify) New Luth	eran Cemetery 201		r, Maryland
Ba	permi Depar Impol any ir		THE PAIR I	2. Name and Address of Facility Eckh 3296 Charmil Drive, I		-
	Ph_sician/		23a Part 1 Enter the disease, or complications that caused the death. Do not en sylock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition			Approximate Interval Between Ons I and Death
	Medical Examiner		resulting in death) a. Due to (or as a consequence of)			56
		er	Secuentially fist conflicts if any, leading to immediate Due to (or as a consequence of):			
	ted Insit	Examiner	cause. Enter Underlying Cause (Disease or iinjury			
	ite be executed hysician and the burial-transit	Ë	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
09	te be iysicia	dical	d			
687	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours a er death. Funeral Director. After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit	Med	IF FEMALE:			1
Box 6		Physician/Me	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)	23d. Date of c	delivery Day Year
P.O.	that the		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute	to the cause of death?
ds,	requires the been signer should be	ted			1 Yes 2 No 3	Probably 4 Unknown
Division of Vital Records,	: The law re cate has be page 2 sh	Completed by			24a. Was an autopsy prior to death? 1 Yes 2 No 1 Yes	
tal	sician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Check on	ly one)	11201
τV	Physi this o	မ	1 Yes 2 10 1 Inpatient 2 ER/Outpati 27. Manner of Death 28a. Date of injury 28b. Time	ent 3 DOA 4 Nursing Home	5 Residence 6 Other (Sp.	ecity) 4705PICE
u o	ding th. After fune	cate	1 Natural 5 Pending (Month, Day, Year) injury 2 Accident Investication	work? M	. Describe now injury occurred	
Sio	Atter	Certificate:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, s		. Location (Street and Number or F	Rural Route Number,
Div	To the Hospital or Attending F within 24 hours at er death. To the Funeral Director Affer completed filled in by the funeral		building, etc. (Specily)		City or Town, State)	
1		Medical	29a. Certifier (Check Medical Examiner: On the basis of examination and/or inve	stigation, in my opinion, death occurred at the	time, date and place, and due to th	e cause(s) and manner stated.
	vithii To th	-	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mor	
)				Jan 1	12 2011 sta MO 21157
2			30. Name and address of person who completed cause of death (Item 23a) (Type, FINU CHACKO 29) Stures	Av	Westmin	sta MD 21157
B	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature			
1			IBBLEN VILLE VILLE AND AND AND AND AND AND AND AND AND AND	Alexander		

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death Month. Vear **Physician** NESLEY AN 2011 /Medical wn, or Location of Death 4c. County of Death Facility Name (If not institution, Examiner more tome 8. Date of Birth (Month, Day, Year) Age (In yrs. If Unde 9. Birthplace, Country) **Funeral** Months 1**⊠**M 2□F Days 212-14-0860 Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No **Funeral Director** timore 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 No Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
ME) DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industr College (1-4or 5+) 501 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ 19a. Informant's Name/Relationship (Type: 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rheims Baltimore Janice 20b. Place of Disposition (Name of pemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death UMONIA Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 DEctopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) 1 Yes 2 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 | Yes 2 | No 3 | Probably 4 | Winknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy this certificate 1∐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 20 No Other: 1 Tes 2 ER/Outpatient 3 DOA ,4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 | Inpatient 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manper of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Natural 5 Pending investigation 1 🗌 Yes 2∏No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2214 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASNEEM 2835 mi 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 24

DHMH 17 Rev 1/2001

Registrar

park

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 11:40AM anuon 01/ Bonnie Lynn <u>Warrington</u> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8004 Woodholme Circle Pasadena Anne Arundel Social Security Number 6. Sex 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Days 1 □ M 2 🕅 Months Hours Marth Day /1959 Yrs. Maryland Director 218-82-3738 Usual Residence of Decedent shov 10a. State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f st notified 1 Yes 2 X No MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? ms 23a or must be r by Funeral permit. Page 1 and 2 should be filed within 72 hours after death with 8004 Woodholme Circle 21122 U.S.A. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner mur 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 1 ☐ Never Married 2 🛭 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Customer Service Utilities Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Richard James Bernard Shirley Margret Kiser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Warrington / Husband 8004 Woodholme Circle, Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 K Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 01/21/2011 Hanover, Maryland 21. Signature of Fun Anatomy Gifts Registry 22. Name and Address of Facility 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between at and Death Immediate Cause (Final Physician disease or condition resulting in death) mon Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown Year Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Completed 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2-12 No ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 24 hours after death. Funeral Director. After this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 5 Pending Vatural 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier 🛮 📿 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one the 29b. Signatur nd title of certifier 6 ne and address of person who completed cause of death (Item 23a) (Type, Print) 0

Registrar

State

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2011 :20 P January Virginia Kay Waller Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Gilchrist Hospice Center Towson 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min 1 M 2 S F Michigan 223-64-2418 Yrs June **Director** 66 Usual Residence of Decedent 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10a, State Director notified 1 Yes 2 X No Elkridge MD Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21075 USA 5925 Abrianna Way Apt F 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status "natural", or ite Black, White, etc. 1 Never Married 2 Married þ White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Program Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ethel Beld Bert Adams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4954 Pale Morning Dun-Elkridge, MD 21075 19a. Informant's Name/Relationship (Type, Print) Jen Burns Daughter injury or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date emetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 1/24/2011 Glen Burnie, MD Atlantic Crematory □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. Signature of Funeral Service License 21. Part 1. Enter the disease, of complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1630 Edmondson Avenue; Catonsvill Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, Immediate Cause (Final Brea Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and dbe detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No Yes 1 Yes Be 26. Place of Death (Check only one) 25. Was case referred to medical examiner? upatient Other: 4 Nursing Home 5 Residence 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA မ After this 27. Manner of Death 28b. Time of 28c. Injury at work? 28a. Date of injury 28d. Describe how injury occurred Certificate: (Month, Day, Year) 5 Pending 1 Natural 1 Yes 2 No Accident Suicide Investigation 6 Could not be Accident within 24 hours after deat To the Funeral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗡 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number (Du 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) w15

Registrar

DHMH 17 Rev 7/2009

State

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 10:45A. M 2. Date of Death Physician/ JaYntary 🗫0,20≇1 James William Walters Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Baltimore Timonium Social Security Number 219-52-7060 8. Date of Birth (Month, Day, Y Oct18.1 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** 1 № M 2 🗆 F Mary Land Yrs Director 61 Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits **Funeral Director** Md. Baltimore City 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224-3031 6711 Graceland Avenue U.S.A. be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No or other traumatic event, the Medical Examiner Black, White, etc. 1 Never Married 2 Married ō Completed by Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify:White "natural" 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry United States (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Letter Carrier |Postal Service 12thBe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Sophie Rolniak မ William Walters permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33487Charlotte Caplan / Sister 6461 N.W. 2nd Avenue, Apt 306 Boca Raton, F1. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State January 4 Donation 5 Other (Specify) 28,2011 Rosary Cem. Baltimore, Maryland Holy 21. Signature of Funeral Service Dicensee 22. Name and Address of Facility Kaczorowski Funeral Home, P.A 1201 Dundalk Avenue Baltimore, Md. 23a. Part 1. Enter the disease, or amplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intérval Between Onset and Death Immediate Cause (Final Physician/ disease or condition ESOPHAGEAL CANCER **Medical** resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of) attending physician and for use as the burlal-transit that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐ 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 X No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE after death. Director: After this the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) 24 hours a Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of dertifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TARIQ MAHMOOD, MD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year, State JAN 2 4 2011 Barks Registrar

a.m.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Robert. Charles Allen 2011 6:30 P January Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel 454 River Road Pasadena 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) [ulv 12,1930 1**火** M 2 □ F Months Days Hours 80 Country) Illinois 330-24-4933 Director July Usual Residence of Decedent 28a-f shov at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified MD Anne Amndel Pasadena 1 Yes 2 X No ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 454 River Road 21122 USA or items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14 Race - American Indian Armed Forces' Armed Follows.

1 X Yes 2 No
If Yes, Give Korean
Year or Dates. War Black, White, etc. 1 Never Married 2 X Married Completed by 72 hours after 21215-0036 1 ☐ Yes 2 X No Specify. White Specify: "natural", 3 Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Color Printing Elementary/Seconday (0-12) College (1-4 or 5+) Company 2 Photo Engraver Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Donald Allen Opal Mesnard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alberta J. Allen / Wife 454 River Road Pasadena, MD 21122 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State January 07, 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) injury or Crownsville, MD MD Veterans Cemetery 2011 21. Signature of 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home Funeral Service Libenses Severna Park, MD 21146 495 Ritchie Hwy. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician drome disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to for as a consequence of: burial-tran and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical that the death certificate be as the l attending IF FEMALE: use yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for (in the past 12 months?

1 Yes 2 No Month Pregnant at time of death the detached 9 Unknown g Unknown P.O. been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, The law requires 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perform death? certificate 1 ☐ Yes 2 ☐ No Division of Vital Was case referred to medical Hospital or Attending Physician; funeral director. 26. Place of Death (Check only one) Be examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA this Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death.

Funeral Director: After (Month, Day, Year) 1. Natural 5 Pending 2 Accident 1 🔲 Yes 2 🗌 No Investigation 6 Could not be the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 only one 29b. Signature and title of certified 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

			State of Maryland / Dep	eartment of Health and N artificate of Death	1ental Hygie	ene 2	011 0126	
			Registrar	Reg. No.				
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		Date of Death Month	Day Yea	3. Time of Death	
	Medic	al	John William Porter	Anderson				
	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of D		
			Coastal Hospice At the Lake 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Salisbury, MD	8. Date of Birth		omico	
н	Funeral Director		213-78-7253 1 X M 2 F 46 Yrs.	Months Days Hours Min.	(Month, Day, Ye)	ear) 9.	Birthplace (State or Foreign Country) aryland	
2			Usual Residence of Decedent		1-3-1304	1 1	aryrand	
	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρī	10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits	
		Director	MD Wicomico Sali	sbury			1 ☐ Yes 2 🗓 No	
			10e. Street and Number	10f. Zip Code	100	g. Citizen of What	Country?	
		Funeral	6060 Oxbridge Drive	21801		USA		
			Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto			merican Indian, /hite, etc.	
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au	be fil ental rked ic ev	욘	Daniel G. Anders	1	,	,	Davis	
Maryland 21215-0036	1 and 2 should of Health and M item 27 is mar other traumat			ing Address (Street and Number or Rura	l Route Number, Ci			
Σ			Cassie Anderson - Wife 6060	Oxbridge Drive, S	alisbury,	Maryla	nd 21801	
Jre,			20a. Method of Disposition 20b. Place of Disp			c. Location - City		
altimore,	Page nent ant: I		A Durial 2 II Oremation 3 II Herioval nom State	Cemetery, ES 1-7-	2011 Н	urlock.	Maryland	
alti	permit. Departn Imports any inju		7		ounds Fur			
<u>m</u>			Thelisoteny Dake.	705 E. Main Street	, Salisbu	ıry, Mar	yland 21804	
п			23a. Part 1. Enter the disease, or computations that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac of	r respiratory arrest,		Approximate Interval Between	
-	mysician/	rii i	Immediate Cause (Final disease or condition	197 7 - 7	wer Het	estases	Onset and Death	
	Medical Examiner		resulting in death) Due to (or as a consequence of):					
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	d sit	nin	rt any, leading to immediate cause. Enter Underlying					
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_	ate be executed physician and the bunal-transit	dical Examiner						
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89	sertifii nding se as	Ž	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of	delivery	
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P.O. Box 687	requires that the death certifics been signed by the attending p should be detached for use as it	Physician/Me	9 Unknown 9 Unknown					
P.	that ned b		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribut	e to the cause of death?	
ds,	quires en sig uld b	Completed by		<u></u>	1 Tes	2 ₺ No 3 🗆	Probably 4 Unknown	
Ö	iw rec is bea 2 sho				24a. Was an autopsy	24b. Were	autopsy findings available to completion of cause of	
Rec	The law ate has bage 2 a	Som			performe	ed? deatl		
<u>ia</u>	ysician: The is certificate director, pag	Be (25. Was case referred to medical examiner?	26. Place of Death (Check				
Ē	Physic this or al dire	은	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie		me 5 🗆 Residenc	ce 6 🗶 Other (S	oecity) Hospice	
0	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and properties of the funeral director, page 2 should be detached for use as the burial-transity.	ate:	27. Manner of Death 1 Natural 5 Pending 28a. Date of injury (Month, Day, Year) 28b. Time of injury (Month, Day, Year)	work?	28d. Describe how	injury occurred	,	
<u>.</u>		Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	M 1 Yes 2 No				
Division of Vital Records,		Cer	4 Homicide determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S		Rural Route Number,	
			29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death	occured at the time, date and place, an	d due to the cause	(s) and manner as	stated.	
	ie Ho n 24 ł ie Fui oletec	Medical	(Check 2 Medical Examiner: On the basis of examination and/or inveorally only one) 3 Certifying Nurse Practioner: To the best of my knowledge	stigation, in my opinion, death occurred at	the time, date and p	place, and due to t	he cause(s) and manner stated.	
	To the within 2 To the Comple	_	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Mo	onth, Day, Year)	
	11/2		Gegerio M. Bellows, M. J	D 29505		01-0	2-2011	
	1xxx	/	30. Name and ardress of person who completed cause of death (Item 23a) (Type,					
	, , ,		GREGORIO M. BELLOSO; 5302 CF	IINABERRY DR.	SALISB	URY, M	1D 21801	
State 31. Date filed (Month, Day, Year) 32. Degistrar's Signature Registrar								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend#10e.PerFHPCC1-11-11cm Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 10:35 PM 2011 Maria Rosario Aramayo January Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rockville Montgomery Casey House - Montgomery Hospice If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Days (Month, Day, Year, March 15, Months Hours Min. Bolivia 1 🗆 M 2 🖾 F 68 579-78-1989 Director Usual Residence of Decedent r 28a-f show notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State death with the Maryland Director 1 X Yes 2 ☐ No Washington DC 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō ral", or items 23a o Examiner must be 3620 39th St., Apt. A535 Funeral Bolivia 20006 39th Street 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11 Marital Status Black White, etc. 1 Yes If Yes, Give ò 1 X Never Married 2 Married 2 X No 72 hours after Baltimore, Maryland 21215-0036 X Yes 2 □ No Specify: Bolivian Specify: Hispanic "natural", 3 Widowed 4 Divorced Completed Year or Dates the Medical 16b, Kind of Business Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Interamerican Bank of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me College (1-4 or 5+) within 7 Elementary/Seconday (0-12) Secretary Be filed 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ည Elena Navarro Abel Antonio Aramayo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 5400 Lanham Station Road, Lanham, MD 20706 Ruth M. Schuett / Friend 20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 1/9/2011 Alexandria, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Squamous Cell Carcinoma Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) death certificate be executed Cause (Disease or linjury that initiated events tranand Due to (or as a consequence of) resulting in death) Last burial physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Month Day 5 Other (specify) Pregnant at time of death signed by the a d be detached f 9 Unknown 9 Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Tes 2 No 3 Probably 4 M Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed' 1 Yes 2 No 1 Yes 2 X No 25. Was case referred to medica 26. Place of Death (Check only one) Be Hospice 1 🗌 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify မှု 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: work? iniury X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatur and title of certifie R143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Debrah Miller, 6001 Muncaster Mill Road, Rockville, MD 20853 31. Date filed (Month, Day, Year, 32. Registrar's Signatu State 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 201^{Year} 6:30 Αм Connie Jean Burgan January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Boonsboro Reeder's Memorial Home Social Security Number if Under 1 Year | If Under 24 Hrs 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1 □ M 2XXF ^CMaryland oct.16,1942 Director 68 212-58-7573 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director 1 ☐ Yes 2XX No Maryland Washington Sharpsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21782 USA 3831 Harpers Ferry Rd. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. Completed by 1 Never Married 2 X Married ☐ Yes 2 🗓 No be filed within 72 hours after altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give "natural". 3 Widowed 4 Divorced Year or Dates White event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If Item 27 is marked other than 'any injury or other traumatic event, the Me once. than Elementary/Seconday (0-12) College (1-4 or 5+) Home 10 Housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Helen Virginia Edwards Charles Edward Kretzer, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2741 Harpers Ferry Rd. Sharpsburg, Maryland 21782 Penny Strite-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖔 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place View Cemetery Jan.10,2011 Sharpsburg, Maryland 4 Donation 5 Other (Specify) soorne Funeral Home, P.A. 425 S. Conococheague St.Williamsport, MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ schemic disease or condition Medical resulting in death) Examiner Sequentially list conditions, il any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of). the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director; After this certificate has I completed filled in by the funeral director, page 2 s autopsy performe Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ၉ Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and little of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2 0063233 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21742 580 Northern Avenue, Hagerstown, MD Dr. Shahid Mahmood 31. Date filed (Month, Day, Year, Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

JAN 10

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jan. Day 011 Year 2. 9:15P M Ralph Howard Bauer Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Salisbury 1205 Frederick Ave. Wicomico Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Funeral 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Hours 1 x M 2 □ F 86 Director 090 18 7214 New Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Salisbury Maryland Wicomico 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1205 Frederick Ave. 21801 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 XYes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. White Specify: Completed 3 X Widowed 4 □ Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ge 1 and 2 should be filed within 72 nt of Health and Mental Hygiene.

E. If item 27 is marked other than 'or other traumatic event, the Me Wheel Bearings Elementary/Seconday (0-12) College (1-4 or 5+) Plant Manager Manufacturer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert L. Bauer Esther R. Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Glancey 1205 Frederick Ave. Salisbury, MD 21801 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Page 1 a 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) First State Crem. Millsboro, DE 1/4/11 21. Sig Juk Fur The Service Ligensee 22. Name and Address of Facility 108 William St. Berlin, MD The Burbage Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CORDNARY DISFASR AR TRRY Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No for Day Year 9 Unknown ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available After this certificate has prior to completion of cause of death?

1 Yes 2 No autopsy performed director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 17 No 은 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opicion death and place. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) within 2 To the 29b. Signature and title of certifier 29d. Date signed Month, Day, Year 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GHULAM 0 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 04 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ JANUARY 2, DOROTHY ANN HAIG BROWN 3:40 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death EASTON TALBOT WILLIAM HILL MANOR Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F MARCH 6. Year) Director 156-18-6917 86 1924 PENNSYLVANIA Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD TALBOT ST. MICHAELS 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 24811 DEEP WATER POINT DRIVE 21663 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give WHITE Specify: 3 Widowed 4 Divorced Year or Dates. the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME other 1 permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ ALFRED VERNON HAIG WILLA ELZARAH HENDREN .. Page 1 and 2 should be tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NORMAN H. BROWN, HUSBAND 24811 DEEP WATER POINT DRIVE, ST. MICHAELS, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION: 1/4/2011 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 200 SOUTH HARRISON STREET, EASTON, MD 216 JOHN 7 MERCERON 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ RICEREBROVASCULAR ACLIDENT Medical resulting in death) Due to (or as a consequence of) Examiner ANGIODATO WALDID Se uentiall, list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran signed by the attending physician and be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant : Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPERCHOLESTEROL 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy perform 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 6 Could not be 1 ☐ Yes 2 ☐ No Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 TLS DOMING DALE AUX State JAN 05

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mary E. Buskirk Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Western Maryland Regional Medical Center Cumberland 9. Birthplace (State or Foreign If Under 1 Year 8. Date of Birth Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Min 1 🗆 M 2 💢 F Days Hours (Month Day, Year) 1944 Maryland 214-42-0393 66 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director Maryland Allegany Lonaconing 1 Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20628 Water Station Run Rd. Funeral 21539-U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Was Decedent Ever in U.S 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Geriatric Nurse Assistant Nursing Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Albert Cutter Mary Winebrenner 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print, 20614 Water Station Run Rd. Lonaconing Maryland 21539-Rhonda Smith daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition rostburg Memorial Park 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State Maryland January 11, 2011 Frostburg 4 Donation 5 Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 **No** Completed 24b. Were autopsy findings available 24a. Was an autopsy performe prior to completion of cause of death? cate has l 1 ☐ Yes 2 ☐ No certificate director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify this Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After th completed filled in by the funeral Manner of Death 28a 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 26 3 Name and address of person who completed cause of death (Item 23a) (Type, Print) State JAN 10

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 20°1'1 Jan 5:23p M Dorothy L. Bender Medical a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 427 Razor Strap Rd. Cecil North East Social Security Number Birthplace (State or Foreign Country)
 WV 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □ M 2 🛣 F Months Days Hours Min Feb 17, Year) 935 77 Yrs. Director 357-26-4364 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD Cecil North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 427 Razor Strap Rd. 21901 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: White 3 XWidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Nurse Medical To Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Clinton White Mary Waneta Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy Bender-Jones/ daughter 183 Beaver Trail Ln. North East, MD 21901 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1/7/2011 cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State R.T. Foard Funeral Home, P.A. 4 ☐ Donation 5 ☐ Other (Specify) Rising Sun, MD 21. Signature of Fun Service Lig 22. Name and Address of Facility R.T. Foard Funeral Home, P. 259 E. Main St. ELkton, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Failure Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any loading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 1

Yes 2

No 3

Probably 4

Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 AN this certificate has page 2 2 X No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 횬 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? within 24 hours after death.

To the Funeral Director: After completed filled in by the funer injury 1 🗷 Natural 5 ☐ Pending __Investigation 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Numo r, determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Pranticiner. To the cost of my included a death cocurred at the life, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 00065013 MD

Registrar
DHMH 17 Rev 7/2009

State

204

31. Date filed (Month, Day,

JAN 06

MO

21921

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Vear Month Francis Gilbert Briddell 11:30 A M Jan 2011 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 7837 Duncan Crossing Road Whaleyville Worcester Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Age (In vrs. last birthday Birthplace (State or Foreign Country) Days Hours 1 → M 2 □ F 218-48-8662 59 May 26,1951 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 ☐ No MD Worcester Whaleyville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7837 Duncan Crossing Road 21872 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11 Marital Status 1 ☐ Never Married 2 ☐ Married African-1 ☐ Yes 2 🖾 No Specify: 3 ☐ Widowed 4 ☑ Divorced American 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Cook Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis W. Briddell Martha E. Armstrong 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha E. Briddell/mother 7837 Duncan Crossing Rd., Whaleyville, MD 21872 20b. Place of Disposition (Name of cemetery, crematory or other place)

Crematory of 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) <u>01/06/2011</u> Delmar, DE Delmarva 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lewis N. Watson Funeral Home, PA 10. aller aule 1618 West Road, Salisubry, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SCLEW11 Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😿 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗆 Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 \sum Nursing Home 1XYes 2 No 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □ Other (Specify) Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending investigation

1 ☐ Yes 2 ☐ No

Location (Street and Number or Rural Route Number, City or Town, State)

Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Division of Vital Records, P.O. Box 68760, attending physician the the been signed by the should be detachhas certificate funeral director, After this

within 24 hours after deat To the Funeral Director: filled in by the

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Examiner

Physician/Medical

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Completed

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3 ☐ Suicide

4 ☐ Homicide

6 Could not be determined

JAN 06 2011

Funeral

Director

id other than "natural", or Items 23a or 28a-f show event, It a Medical Examinar must be notified at

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene important: if item 27 is marked other than any injury or other trainmatic.

Physician

/Medical

Examiner

Certification: To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 910 31. Date filed (Month, Day, Year) 32/ Registrar's Signature State

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

ack

Please Type or Print in Black Indelible Ink Ensure All Gonies Are Legible.

Amend 20b per Fil 26 per med State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician/ BUTCHER 8:49 TORRAINE HELEN JAN WAR 201 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner DWSON BALTIMORE JOSEPH MEDICAL CENTER If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Age (In yrs. last birthday) Funeral 1 ☐ M 2 🛣 F (Month, Pay, Year) Days Pennsylvania Months Hours Min 76 215-30-0856 Director Usual Residence of Decedent 10h County 10d. Inside City Limits 10a. State 10c. City. Town or Location Director must be notified Aberdeen 1 Yes 2X No Harford MD. 10g. Citizen of What Country? 10f. Zip Code 5 10e. Street and Number Funeral 23a 21001 316 Apt. United States 601 Cornell Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. ori permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatin þ 1 Never Married 2 Married 21215-0036 1 Yes 2X No Specify: If Yes, Give Year or Dates Specify: White Completed 3 N Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home Housewife unknown Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Smith Lewis Wright Alfred Emily Helen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21161 19422 Burke Road Bruce L. Blizzard (Nephew White Hall, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Highvi Gardens 2011 Fallston, Maryland 22. Name and Address of Facility E.G. Kurtz & Son Funeral Jarrettsville, Maryland Home, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Physicianz RUSBIRATORY FAILURE Medical resulting in death) Due to (or as a consequence of Examiner FAILURE Congestive Sequentially list conditions Examine Dus to (chas a consequence of): if any, leading to immediate cause. Enter Underlying PULMONARY DISCASE Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events OBSTRUCTIVE Due to (or as a consequence of) resulting in death) Last the burial Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Day g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by MITRAL REGURGITATION 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 Yes 2 No Yes 2 No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No Other: ပ 1 Tes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at 27, Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one)

State Registrar 29b. Signature and title of certifier

TIMETHY

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Low

DHMH 17 Rev 7/2009

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32. Registrar's Signature

2403

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Crew Lenora В January 50 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death <u>710 Lanvale St</u> Hagerstown Under 1 Year | If Under 24 Hrs. Washington 6. Sex 7. Age (In vrs. last birthdav 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland Funeral 1 □ M 2 🛛 F Months Days Hours Min. Director 219-12-1907 90 Usual Residence of Decedent 23a or 28a-f show "natural", or items 23a or 28a-f sho 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 412 N. Jonathan St should be filed within 72 hours after death and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces OF. Black, White, etc. 1 🔀 Never Married 2 🗌 Married <u>S</u> ☐ Yes 2K No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Specify: Black Completed 3 Divorced 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour popartment of health and Mental Hygelen. Important: If item 27 is marked other than "natuu any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Teacher <u>Career Study</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Frank Crew Janev Rebecca Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Constance R. King / Niece</u> 204 N. <u>Jonathan St., Hagerstown, MD 21740</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest haven Cemetery 11,2011 Hagerstown, MD Jan. Signature of Funeral Service Licenses 22. Name and Address of Facility Gerald N. Minnich Funeral Home Potomac St., Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) epro-vescu Medical Due to (or as a consequence of) Examiner quantially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): s been signed by the attending physician should be detached for נוגם בי בייביי Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Day Year 4 ☐ Pregnant a 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has ours after death.

Neral Director: After this certificate has filled in by the funeral director, page 2. autopsy performed. 1 ☐ Yes 2 No Yes 2 A No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 2 Residence 6 Other (Specify) 1 ☐ Yes 2 ♣ No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending iniury Accident 1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie

5H-6 State

> Registrar DHMH 17 Rev 7/2009

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31. Date filed (Month

30. Name and address of person who completed cause of peath (Item 23a) (Type, Print)

0484

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

1-7-11

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 15:21 PM 201 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Battimore Maryland Medica **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F October 4, 1947 228-72-4581 63 New York Director Usual Residence of Decedent and Mental Hygiene.
Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Tant. If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Middletown 1 🗌 Yes 2 🗶 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 103 Tobias Run 21769 United States of America 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 11. Marital Status Armed Forces 1 Never Married 2 X Married 1 Yes 2 K No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: White Specify: 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Samuel Baxter Helen Swihura 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert F. Cavanaugh / Spouse 103 Tobias Run, Middletown, Maryalnd 21769 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott cemetery, crematory or other place)
Christ Reformed United
Gurch of Christ Cemetery January 15, 1 X Burial 2 Cremation 3 Removal from State Middletown, Maryland 4 Donation 5 Other (Specify) 2011 22. Name and Address of Facility **Keeney & Bastord P.A. Funeral Home** M01433 106 East Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to for as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director After this certificate has been sinned by the attending hours and the funeral Director After this certificate has been sinned by the attending hours. attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth Z L 1 Glass 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 2 No To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 M No Certificate: To 1 🗌 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 ☑ Natural 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 ☐ Yes 2 ☐ No s after death. Il Director: A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Effectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 1659696193 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) University of Md Medical Center 22 S Greene St, Bathmara, MO 21201 Berry MD State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY GEORGE BENSON CHAPMAN, SR 2011 07:30 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 75 COKESBURY ROAD PORT DEPOSIT CECIL Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday, 8. Date of Birth **Funeral** Days 1 XM 2 □ F Hours Min. MAY 26, 1931 220-22-5800 79 **Director** MARYLAND Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f MARYLAND CECIL 1 🗆 Yes 2 🔀 No PORT DEPOSIT ö 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must be Funeral 75 COKESBURY ROAD 21904 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married X Yes 2 ☐ No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK "natural", Completed 3 X Widowed 4 Divorced Year or Dates. 1953-55 of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical. 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) SHOP STEWARD TUNNEL MANUFACTURE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ALBERT WILSON CHAPMAN, SR permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. ALICE REBECCA YOUNG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VICTORIA CHAPMAN BERRY/DAUGHTER 75 COKESBURY ROAD, PORT DEPOSIT, MARYLAND 21904 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MT ZOAR A.M.E. CEM. 1/11/11 CONOWINGO, MARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility
LISA SCOTT FUNERAL HOME
552 LEWIS STREET, HAVRE Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Cance Stomach Unh nown disease or condition Medical resulting in death) Due to (or as a consequent of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of has autopsy performed death? After this certificate 2 No 2 N Yes 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Al completed filled in by the fu 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10023322 Jachder 5 M 1.7.2011. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elkten MD 21921. 5+IVA 126 4 31. Date filed (Month, Day, Year, 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Monthan 14, 2011 Year Physician/ Crabtree 3:00 AM Francis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death WMHS-RMC Cumberland Allegany 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 1 🗆 💓 2 🗆 F [™]Mav°′27″. 192β 216-18-1112 MD **Director** 87 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Allegany MD Cumberland 1 🗆 🔀 s 2 🗆 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 1025 Cherrywood Avenue USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. WWII 3 ☐ Widowed 4 ☐ Divorced Specify. white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sheet metal worker Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Cecilia (Helmstetter) Crabtree Lester Crabtree 19a. Informant's Name/Relationship (Type, Print)
Doris Crabtree 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1025 Cherrywood Avenue Cumberland MD 21502 wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State SS Peter & Paul Cemetery 1/17/20 MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Ser 22. Name and Scarpelif Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Pay 1. Enter the gisease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Bilateral one day Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate be completed filled in by the funeral director, page Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 🔀No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier workethish MD 00055325 Jan 14, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) walsh Rd cumberland MD 21502 925 Bishop MONSOCK 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

The sale

Please Type or Print in Black Indelible Inf. Ensure All-Comics Are 1/2016 dk. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2011 3. Time of Death Physician/ Mary Etta Crawford -2010 A M 1:25 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick College View Center Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 9. Birthplace (State or Foreign **Funeral** 1 2 M 2 X F Months Days Hours Min 76 214-32-4762 Maryland **Director** August 4, 1934 Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10d. Inside City Limits death with the Maryland 10c. City, Town or Location Director Maryland Frederick Frederick 1 X Yes 2 ☐ No 10f. Zip Code 0 10e. Street and Number 10g. Citizen of What Country? ral", or items 23a or Examiner must be 21701 424 Sherman Avenue Funeral United States of America Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced than "natur he Medical f 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the Nonce. Publications Computer Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Norris Hagan Stella Frances Moser Page 1 and 2 should be in ment of Health and Ments 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8416 Foresight Lane, Walkersville, Maryland 21793 Todd Crawford / Son 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 🗷 Burial 2 🗌 Cremation 3 🗀 Removal from State January 5 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 2011 Resthaven Memorial Gardens 21. Signature of Inglatery Licentee 22. Name and Address of Facility
Keeney & Bastord P.A. Funeral Home
106 East Church Street, Frederick, Maryland 21701 M01433 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) neumonia . Medical ue to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and that initiated events Due to (or as a consequence of). resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown detached g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 should be 1 ☐ Yes 2 ☐ No Probably 4 ☐ Unknown Umanav Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed certificate 2 🗆 No Yes 2 1 🗌 Yes completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one, Be examiner? 2 \ No 1 Inpatient 2 I ER/Outpatient 3 I DOA မ Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work' s after death. 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signatur and title of certifier 1-3-2011 D60417 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick MD 21702 Tohnson homas shall . Date filed (Month, Day State JAN 20

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician MARILYN BAUMAN DECKER 2 2011 3:35 AM Jan /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Talbot Genesis HealthCare -The Pines Easton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/02/1934 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 □ M 2 X F 76 NJ Director 138-26-1505 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show 1 ☐ Yes 2 No Director **EASTON** TALBOT MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 610 DUTCHMANS LANE 21601 UNITED STATES Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 Never Married 2 Married ò 1 ☐Yes 2 X No Specify. Completed by Specify: WHITE 3X Widowed 4 ☐ Divorced 'naturaj' 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12 \end{array}$ College (1-4or 5+) MUSICIAN HEALTH CARE other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be marked HERBERT BAUMAN DOROTHY SMITH ပ္ Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) S permit. Pages 1 and Department of Health important: If Item 27 any injury or other to once. 27 31696 WINDY LANE, TRAPPE, MD 21673 BRADFORD L. DECKER / SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION 01/03/2011 STEVENSVILLE, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. MERCERON 200 SOUTH HARRISON ST., EASTON, MD 21601 JOHN R. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to with cecebral metastases Examiner Sequentially list conditions, Examiner in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated assets) physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Month Day Year 5 Other (specify) certificate has been signed by the irector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an sanic autopsy performed 1 🗆 Yes 2 5 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Natural 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 □ Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

The law requires that the death certificate be executed P.O. Box 68760 Division of Vital Records, vine Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this continuous completely filled in hour. 125

Marilyn Decker Baltimore, Maryland 21215-0036

State Registrar

ROWLLEY MICHAEL

29b. Signature and title of certifier

MD 610 DUTCHMANS JAN 03 2011

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

3

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jan 13, 2011 Physician/ 5:20 PM Clora Mae Doyle Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cumberland Allegany New Hope Assited Living Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □ F_X Hours Apr 23, Country) 229-24-4052 1923 Director 87 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD Washington Hagerstown 1 Dixes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21740 17322 Gav Street USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 🗆 Yes 2 🗆 📉 than "natural", 3 Nidowed 4 Divorced white Year or Dates event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) n 27 is marked other than " r traumatic even" Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be Filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Hattie (Guthrie) Barton James Barton permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) iiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11903 Old Williams Rd. Cumberland MD 21502 Peggy McCoy daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Scarpelli Funeral Home, P.A. 20c. Location - City or Town, State Date ☐ Burial 2 ☐ CXemation 3 ☐ Removal from State 1/14/2011 MD Cresaptown 4 Donation 5 Other (Specify) 22. Name and Scarpe IIF Funeral Home, PA 21. Signature of Funeral Service Licenses 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1 Enterthic disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) CORDNAR Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death 5 Other (specify) 2 should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes After this certificate has been 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? page 2 No Yes 2 No 1 Yes Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 잍 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No injury 1 Matural 5 Pending after death Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 - Homicide determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as statted. To the within 2 To the F only one) Signature/and title of certifier 29d. Date signed (Month. Day, Year) \sqcap mpleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who c JR.M.D 200 GLENN ST. STE ISTIANOJ

Registrar

filed (Month, Day, Year N 2 4 2011

32. Registar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 04 2011 Clarence Edward Dorm, Sr. 2052 Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster, MD Carroll 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1. □XM 2 □ F Hours 11/08/1925 220-18-0716 85 Maryland Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Tes 2 No Westminster, MD Carroll 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 828 Western Chapel Road 21157 United States hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian rmed Forces? Black White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates. Completed 3

Widowed 4 □ Divorced 1944-1946 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Importants: If item 27 is marked other than 'any injuy or other traumatic event, the Mel Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Earl Dorm Carrie Dorsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maybelle Randolph/Daughter 6 UnionStreet Westminster, MD 21157 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Lake View Cemet 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Cemetery 01/10/2011 Sykesville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facilities that it is the state of the state o Signature of Funeral Sorvice Dicensee Pritts Funeral Home412 Washington Road 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) min Medical a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 9 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No 1 ☐ Inpatient 2 KER/Outpatient 3 ☐ DOA Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Naturai injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🗗 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Sign 29c. License number 29d. Date signed (Month, Day, Year) WJL 6+1VA nd address of per se of death (Item 23a) (Type, Print 688 Poole MD

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Reg

strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 110 DYUN hristo ominic Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 34711 pito enter ON resimins If Under 1 Year If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 6. Sex 1X M 2 □ F 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Months Days Hours (Month, Day, Year) 10/05/1930 Director 215-26-1283 80 MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1021 Valen Road 21157 USA 12. Was Decedent Ever in U.S. Armed Forces?

12 Yes 2 No 194
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 XMarried 2 No 1948 Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 Divorced 4 Divorced 1949 Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) State Trooper MD State Police Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Nicola Dattilio Rosa Prospera 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M. Jayne Dattilio/wife Valen Road, Westminster, MD 21157 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date X Burial 2 Cremation 3 Removal from State 101/06/2011 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Memorial Finksburg, MD 22. Name and Address of Facility Pritts Funeral Home & Chapel Signature of Funeral Service Licenses facel Mark 412 Washington Road, Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician HON disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Bowel Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or linjury Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 5 Other (specify) Month Year 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? After this certificate 1 🗌 Yes 1 Yes To the Funeral Director, After this certifics completed filled in by the funeral director, I 26. Place of Death (Check only one) B 25. Was case referred to medical Hospital 1 🗌 Yes 2 No Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) WJL 20059943 12011 10+1 VA ompleted cause of death (Item 23a) (Type, Print) 30. Name and address of pe 8nn (wesminspr 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2<u>011</u> Physician/ Michael DeProspo 1:17 A.M anuary 1 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Carrol1 Westminster 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 ፟ M 2 ☐ F 017017 Pay Year) Director 129-54-0723 51 NY Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🎽 No MD Frederick Jefferson 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 4824 Old Holter Rd 21755 death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) +2 Insurance claims adjuster Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Antoinette D'Amico Michael DeProspo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryann DeProspo-wife 4824 Old Holter Rd., Jefferson, MD 21755 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Mem. Gar. 01/06/2011 Frederick, MD 21. Signature of Funeral Service Licen 22. Name and Address of Facility Stauffer Funeral Homes, Pike, Frederick, MD 1621 Opossumtown 23a. Part 1. Enter the dise complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failur n each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ravs Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician; The law requires that the death certificate be executed Cause Disease or impury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year the & 9 Unknown rate nas been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? nin 24 hours after death.

The Funeral Director, After this certificate In pleted filled in by the funeral director, pagn 2 🗌 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 NR/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 30. Name and address of person who completed cause of death (Hem 23a) (Type, Print)
1-10 (NI) 2 14 D Hours Pism Jr MD 2973 Manchester RJ Wanchester

DHMH 17 Rev 7/2009

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Proserva

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year Physician/ 1:00 P M Joseph Francis DiRenza 01 2011 Medical Eacility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Spic 0 mi **9**ex 1 **X** M 2 □ F If Under 1 If Under 24 H s. 8. Date of Birth 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign cial Security Number **Funeral** NOV. 20, Year) 945 Months Hours PENNSYLVANIA 155-34-1384 65 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 X Yes 2 No MARYLAND WORCESTER OCEAN CITY 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral UNIT I 120TH STREET 21842 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 X Married WHITE 1 ☐ Yes 2 X No Specify. Specify 3 Widowed 4 Divorced Year or Dates.1966-69 th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) t be filed within fental Hygiene. PURCHASING AGENT BANKING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. ALICE PHARAZYN Joseph R. DiRenza 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 120TH ST., OCEAN CITY, MD 21842 Katherine M. DiRenza/Wife 102 UNIT I 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State DELAWARE VETERANS CEMETERY 4 Donation 5 Other (Specify) 1/6/11 MILLSBORO, DELAWARE uz ral S viz e License 21. Signav re 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Onset and Death Physician 0% ARCINDMA We NTH Medical resulting in death) Due to (or as a consequence of): Examiner Esque titing liet or differe, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Month Year Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performe 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: HOSPICIZ 4 Nursing Home 5 Residence 6 Sther (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3/21 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 00058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) @ Huism 130 10

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Registrar

31. Date filed (Month, Day, Year) AN 05 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Amend 19b. Per Family PGC1-10-2011 cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 201^{Ye} George C. Denney 8:00 A. January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Collington Episcopal Life Care Nursing Home Mitchellville if Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Days Hours - 19<u>21</u> July 18 175-14-3951 Director 89 Pennsylvania Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location the Maryland the Medical Examiner must be notified at 10d. Inside City Limits Director D.C. Washington 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with or items 23a Funeral 2604 36th Street N.W. United States 20007 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White "natural", 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government Foreign Affairs Expert other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked of ည should be George C. Denney Crowthers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Jill Denney/ Daughter 2604 36th ptreet N.W. Washington, D.C. 20007 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Geometry crimaton or interplaced by January Medical Center 2011 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. injury 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Columbia Mortuary Services, P.A. Signature of Funeral Service Li any /M00969 9013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Onset and Death Physician/ ocardia Medical resulting in death) Due t (or as a consequence of): Examiner Esquentially liet conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a donsequence of): -transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events physician and resulting in death) Last Due to (or as a consequence of): the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 for use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death signed by the a d be detached f Yes 2 No g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 2 should 24b. Were autopsy findings available 24a. Was an After this certificate has autopsy prior to completion of cause of death? page 1 Yes 2 No 2 X N Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital No No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural Accider (Month, Day, Year) injury 5 Pending death. 1 Yes 2 No М Accident Investigation within 24 hours after death To the Funeral Director the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined building, etc. (Specify) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29c. License number person who completed cause of death (Item 23a) (Type, Print)

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State

Registrar

31. Date filed (Month, Day, Year)

JAN 1 0 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death M9nth Physician/ 133/ DIETER HELEN ANN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 100mics If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛚 F ocT. 25 MARYLAND Months Days Hours Min 219-30-5380 76 **Director** Usual Residence of Decedent or 28a-f show 10a State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits the Medical Examiner must be notified at Director 1 X Yes 2 No MARYLAND WORCESTER OCEAN CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? , or items 23a Funeral 9204 CARIBBEAN DR. 21842 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. è 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: "natural" 3 Widowed 4 Divorced Specify: WHITE Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) SECRETARY CITY GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be WHITMER LINDSAY HELEN REILLY other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 9204 CARIBBEAN DR,, OCEAN CITY, MD 21842 JAMES J. DIETER JR./HUSBAND Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 5 Other (Specify) BERLIN, MARYLAND SUNSET MEMORIAL PK 4 Donation 1/15/11 21. Sign sure f Superal Socice 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 Part | Enter the disease, or complications that raused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of peach line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ Se disease or condition show Medica! resulting in death) Due to (or a a consequence of): **Examiner** Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death detached a 🗌 Unknown 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy perform certificate h Yes 24 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be 2 No Hospital: 2 1 🔲 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation completed filled in by the 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 To the I only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) D41721 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEPMAN 400 E. SHORE DR. SALISBURY 21804

Registrar

31. Date filed (Mont

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Janvari 15:08 Physician 2011 erry Lee /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1**XX**M 2□F 59 11, <u>Pennsylvania</u> 183-44-8313 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show Examiner must be notified at 1 ☐ Yes 2√√ No Director MD Carroll Westminster 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code ō USA 21158 4664 Band Hall Hill Road 'natural", or items 23a Funeral Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2/X No Specify: Specify: White <u>م</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education the Medical (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Home Improvement 12 Contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Wedlock Paul Evler ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a important: If item 27 is 4664 Band Hall Hill Road, Westminster, MD 21158 <u>Toni M. Eyler</u> 20b. Place of Disposition (Name of cemetery, crematory or other place)
Kenworthy Funeral Home, Inc. 1/6/2011 20c. Location - City or Town, State 20a. Method of Disposition
1 Burial 2 Cremation Removal from State Hanover, PA 17331 4 ☐ Donation 5 ☐ Other (Specify) any injury 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kenworthy Funeral Home, Inc. CC0354 269 Frederick Street, Hanover, PA 17331 23a. Part 1. Enter the disease, or complications that caused the death. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocardia Om.h Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, lecting 1, immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy Day Month Yea for in the past 12 months? 5 Other (specify) Yes 2 No by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by director, page 2 should be 2 No 3 Probably 4 Unknown peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate has 1 Yes 2 No 2 V No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home Hospital: 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) ည this within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Division 1 Natural (Month, Day Year) or Attending 5 Pending investigation Injury 1 Yes 2 No Μ 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only 29c. License number 29b. Signature and title of certifier MD 0287/0E WIL HANOVER 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 112 CLOVER LANZ JOHN LUNSFORTMI) 733

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 0 6 2011

32. Redistrar's Signature

	Funera Directo	a)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at	
	Physicia	1
4	Physicia /Medica Examine	
Division or Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	

		1 - State Ammended box 19b Per FH	Maryland / Depa WSH Carroll Ce				g. No.	3. Time of Death				
Physici /Medic		Decedent's Name (First, Middle, Last) PAUL EUGENE EBAUGH				JAN 3,	Day Year	8:20 AM				
Examir		4a. Facility Name (If not institution, give street and numb 320 ROBERTS MILL ROAD		4b. City, Town, or TANEYT			4c. County of Death					
Funeral Director	or	5. Social Security Number 6. Sex 7.05-10-4892 6. M 2 F 7.	Age (In yrs. last birthday) 98 Yrs.	if Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan 25	Year) Con	nplace (State or Foreign untry) aryland				
show ed at		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No				
or 28a-	Director	Maryland Carroll 10e. Street and Number	Taneyt	10f. Zip Code			g. Citizen of What Co	untry?				
ns 23a must b	Funeral I	320 Roberts Mill Road 11. Marital Status 12. Was Decede	ent Ever in U.S. 13.1	2178 Was Decedent of Hi			Jnited St					
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Hygier other the		17. Father's Name (First, Middle, Last)	Eng	ineer	18. Mother's Name	(First, Middle, M	Railroad aiden Surname)	1				
Mental arked c	To Be	Chester Allen Ebaugh			Estella							
Department of Health and Menital Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show with flury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type. Print) Carl E. Ebaugh/son	19b. Mailir 320	ng Address (Street a	Mill Ro	al Route Number, Taney to L, Tane	City or Town, State, Z Wh YEWOR, MI	(ip Code) D 21787				
nent of He int; If Item iry or oth		Carl E. Ebaugh/son 320 Roberts Mill Rd, Taneytwon, MD 21787 20a. Method of Disposition XID Burial 2 Cremation 3 Removal from State St. John S(Leisters) XID Donation 5 Other (Specify) Lutheran Cemetery 1/7/11 Westminster, md										
Importa any inju		21. Signature of Funeral Service Licensee	22	2. Name and Addres ers-Durk	s of Facility			4D				
ysician		23a. Part Enter the disease, or complications that cause on each k, or heart failure. List only one cause on each immediate Cause (Final		er the mode of dying	g, such as cardiac o	or respiratory arre	st,	Approximate Interval Between Onset and Death				
/ledical aminer		disease or condition resulting in death) a Due to (or	a consequence of):	a-tec	- di	serse		20 11000				
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To th comp	Me	29b. Signature and title of certifier	00	29c. License			d. Date signed (Monti	h, Day, Year)				
5		30. Name and address of person who completed cause	of death (Item 23a) (Type.	Print)	1500680 Han	3L)	414ary 3	,2011				
1-		Kurt K. Thomas, D.O.	136 PE	nn St.	Han	ver,	Pa. 17	733/				
Sta Registi	_		gistrar's Signature	bare								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 45 A M Januer 2011 Annie Lois FRANKLAND Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10711 Oak Forest Drive Hagerstown Washington Birthplace (State or Foreign Country) Social Security Number If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthdav) **Funeral** 1 □ M 2**X** F Months Days Hours Min. (Month, Day, Year) **Director** 19 1933 419-38-1134 Alahama Nov. ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10711 Oak Forest Drive 21740 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 █ No if Yes, Give 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ed other than "natural", or event, the Medical Examin Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Specify: 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. tant: If item 27 is marked other than lury or other traumatic event, the IN 12 Homemaker Her own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည <u>James Gus Russell</u> Lillie B. Russell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven Franklin - Son 10711 Oak Forest Drive, Hagerstown, Md. 21740 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) Paul's Cemetery 1/10/2011 Clear Spring, Maryland Signature of tineral Service Lice Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death ₽nysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner aseuli Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending housing many the attending physician and hed for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death should be detached 1 ☐ res ∠ ⊑ g ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? ours after death. eral Director: After this certificate h filled in by the funeral director, page 1 Yes 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗷 No Hospital: Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 \(\bigsize\) Nursing Home 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No. Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JAN A ?

mack

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1/3/2011 Margaret Virginia Fleming 3:50 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Country Companions Assisted Living Carroll Taneytown Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🗶 F Months Days Hours Min 9/12/1916 214-01-7746 94 MD **Director** Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City. Town or Location with the Maryland 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD Carroll Taneytown 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? items 23a or ner must be r Funeral 3217 Bert Koontz Road 21787 USA · death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Examiner Armed Forces? Black, White, etc. ò þ 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates Specify: White "natural" Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Teacher Schools traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked o ge 1 and 2 should be fil of of Health and Mental :: If item 27 is marked 2 Carrie Brown Birnie Bowers Harman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Fair/daughter 4722 Piney Creek Road, Taneytown, MD other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or otl 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 01/07/2011 Finksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Memorial Signature of Funeral Service 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA 412 Washington Road, Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physiciani disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner it any seeing to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innerial inversion, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 N Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No 1 Yes Other: 은 4 Nursing Home 5 Residence 6 Other (Specific 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 20a Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. re and title of certific 29d. Dalle sign WJL

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

10

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Carol Sue GARDNER Medical P M <u>Jan</u> 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 417 West Church Street Hagerstown Washington Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 - M 2 X F Hours Month: Director Country) 216-80-8986 1959 Jan. 4 Maryland Usual Residence of Decedent or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County the Medical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits Maryland Washington 1X Yes 2 No Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 417 West Church Street 21740 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian ģ 1 Never Married 2 X Married 1 ☐ Yes 2 💢 No If Yes, Give Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. 3 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 <u>Billing Supervisor</u> Be Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Clarence Melvin Horning Roxy Delores Hartman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 23 any injury or other t Todd Gardner - Husband 417 West Church Street, Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place Donation 5 DOther (Specify) Cedar <u>Lawn Mem.</u> Park 1/10/2011 Hagerstown, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Day 2 No Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed' Yes 2 X No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) ပ္ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury Accident
Suicide Investigation 1 ☐ Yes 2 ☐ No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Location (Street and Number or Rural Route Number, City or Town, State) Medical Descritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29c. License number 29d. Date signed (Month, Day, Year) 0006323 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mahmood 550 C Northern Ave Hagerstown mo State Registrar's Signature Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		_ For	Pleas	se Type or F State of				k. Ensure A Health and I	-		.egible.	
	_	State Registrar				Cer	tificate of	Death		Reg. No.	011	01293
Physicia Medic		1. Decedent's Name Willian	m Lyon		Gardine	er			2. Date of De Month January	7 3,	2011	3. Time of Death 7:00 A M
Examin	er	4a. Facility Name (if 204 Wes1		rive street and numb	er)			r Location of Death Plata	n	4c. Co	ounty of Death Char	1 60
Funeral Director		5. Social Security No. 215-52-54	umber (. Age (In yrs. I			If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da April	th ly, Year) 4 . 1947	9. Birthp	lace (State or Foreign
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Maryland 28a-f sho otified al	Funeral Director	MD	Ch	arles	Tuc. Cit	ty, Town or Lo La	Plata	<u> </u>			1	1 Yes 2 No
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filed within 72 hours after death with the Maryland at Hygiene. I other than "natural", or items 23a or 28a-f show went, the Medical Examiner must be notified at	ē	11. Marital Status 1 K Never Marri 3 Widowed	ied 2 🗆 Marrie	12. Was Deceded Armed Force 1 Yes 2 If Yes, Give	es? ! XNo		Was Decedent of H	dispanic Origin? (Span, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14.	Race - Americ Black, White, e	etc.
12 should be filed within 72 hours aft. aith and Mental Hyglene. 27 is marked other than "natural", r traumatic event, the Medical Exar	Completed		15. Decedent cify only highes	Year or Date s Education grade completed) College (1-4		(Give	dent's Usual Occup kind of work done O NOT use retired)	during most of wor	king	16b. Kind of Business Industry		
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12 should be alth and Men 27 is marke r traumatic		19a. Informant's Na George		r,III/Bro	ther			and Number or Ru Lane, La				Code)
permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau				B ☐ Removal from Secify)	tata 0	cemetery, cren	sition (Name of natory or other pla s Cemete	ce) ery 1/8/	Date 2011		tion - City or To	
permit. Departn Imports any inju		21. Signature of Fur	neral Service Lic	ensee E. L. L	MO0'945)	22	AREHARI ^{dre} 211 St.	ECHOLS FU	JNERAL H	OME,P.	A. 206	46
Physician/ Medical Examiner			rt failure. List on Final	omplications that car y one cause on each a Due to (or		n a	-	ng, such as cardiac		rest,		Approximate Interval Between Onset and Death
executed an and rial-transit	al Examiner	Sequentially list concause. Enter Under Cause (Disease or that initiated events resulting in death) I	iinjury	c. De	as a consequence of the second	tes -	nell	tus				
ath certificate attending phys for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?		rth 2 Teta nt at time of a	al death 3	Ectopic pregnan Other (specify)	су		230	d. Date of delive Month	ery Day Year
requires that the des been signed by the s should be detached	ted by P	Part II. Other signif	icant condition	s contributing to dea	th but not res	sulting in the u	inderlying cause gi	ven in Pa I.	-			e cause of death?
The law re rate has be page 2 sho	Completed by	perip	horal 1	verente	rea s	2091	, ange	ina,	24a. Was auto perfo 1 Yes			osy findings available mpletion of cause of
ician: certific rector,	Be	25. Was case referred examiner?		Hospital:			Oth	iace of Death (Chec	37			
ding Phys h. After this funeral di	sate: To	27. Manner of Death 1 Natural 2 Accident	n 5 🗌 Pending	28a. Date of (Month,		28b. Time of injury	28c. Injur	4	lome 5 Residence)
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 to ompleted filled in by the funeral director, page 2.	Certificate:	3 Suicide 4 Homicide	Investiga 6 Could no determin	ot be 28e. Place of	Injury - At ho , etc. (Specify	ome, farm, stre	eet, factory, office		28f. Location (\$ City or Tov		umber or Rural	Route Number,
he Hospitt in 24 hours he Funera pleted fille	Medical	(Check 2	☐ Medical Ex	hysician: To the bes aminer; On the basis lurse Practioner: To	of examination	n and/or invest	tigation, in my opini	on, death occurred a	at the time, date a	and place, an	d due to the cau	ise(s) and manner stated
vith vith com		29b. Signature and	title of certifier	Julakel	I m	U	29c. Licens	e number	70		igned (Month, L	
7R7				no completed cause				MD 207	1.6			
Stat Registra		31. Date filed (Monti		M.D. La (irange istrar's Signa		tall sale	a,MD 206	40			

i,				d / Department of Health and N		_
3		•	1 _ State	Certificate of Death	Reg.	2011 01201
()			Registrar 1. Decedent's Name (First, Middle, Last)	307.67704.0	2. Date of Death	3. Time of Death
EK	Physicia Medic		Leaters Gaylord, J	r.		Day AON 150 PM
1-	Examir		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Peath		4c. Cou <i>n</i> ty of Death
EA			VA Maniford Health Care Sys	tem Perry Point	MD	Cecil
7	Funeral		5. Social Security Number 6. Sex 1 M 2 \square F 7. Age (In yrs. las	st birthday) Yrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Mar 12	9. Birthplace (State or Foreign Country)
~	Director		Usual Residence of Decedent		Mar. 12.	1934 New York
N. S.	and show	힏		Town or Location		10d. Inside City Limits
9	Mary 28a-f otifie	irec	Maryland Cecil	Port Deposit		1 ሺ Yes 2 □ No
SAYLORD	h the	밀	10e. Street and Number	10f. Zip Code 21 904	10g.	Citizen of What Country?
O	tth wit ms 2; must	Funeral Director	36 Race Street 11 Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Spr	ocify Vee or No-	14. Race - American Indian,
(0	er dea or ite niner	y F	Armed Forces?	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
200	rsaftu Iral", Exar	ed k	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.	1 ☐ Yes 2 ☑ No Specify:		Specify: Black
Physcian 21215-00	2 hou "natu edical	Completed by	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work	ting 16b	. Kind of Business Industry Chester Gas &
₹ 2	thin 7 ene. than the Me	l mo	Elementary/Seconday (0-12) Twelve Years College (1-4 or 5+)	life. DO NOT use retired) Meter Reader		Electric
الك 24	ed wi Hygit other	Be (17. Father's Name (First, Middle, Last)		ne (First, Middle, Maid	chester, New York
<u>a</u> 2€	be fill ental rked ic ev	2	Leaters Gaylord, Sr.		argaret Ha	
ary ary	hould and M s ma	- 20	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Run	al Route Number, City	or Town, State, Zip Code)
known ore, Man	nd 2 s ealth a n 27 i		Florence J. Marshall (sister)	599 Fort Drive, Westan	mpton, New	Jersey 08060
Jame Known to Physican Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			metery, crematory or other place)	Date We	Location - City or Town, State
Jame Baltim	tt. Pag rtmen rtant: njury		4 □ Donation 5 □ Other (Specify) R.A.	Ferris & Co., Inc. 01/		Pennsylvania
Bal Bal	perm Depa Impo any ii	10	21. Significant of Funeral Service Licensee	22. Name and Address of Facility Lee A. Patterson & Perryville, I	Son Funer	al Home, P.A.
			23a. Part 1. Enter the disease, or complications that caused the death.			Approximate
سر <u>وا</u>	Ph sician/	l o	shock, or heart failure. List o <i>n</i> ly o <i>n</i> e cause on each line. Immediate Cause (Final disease or condition	COLON CANCEL		Interval Between Onset and Death
	Medical		resulting in death) a. Due to (or as a consequence)			
7	Examiner	<u>.</u>	Sequentially list conditions, b.			
	ed sit	cal Examiner	if any, leading to immediate Due to (or as a consequence cause. Enter Unicer) importance. Cause (Disease or linjury	ence of):		2
	be executed sician and burial-transit	Exa	that initiated events c. Due to (or as a consequence of the constant of the co	ence of):	*****	
0	ath certificate be exattending physician for use as the burial		d			
68760	tificat ng ph as th	Mec	IF FEMALE:			
9 ×	th cer ttendi or use	jan/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnan	death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
Вох	e dea the a	Physician/Medi	1 ☐ Yes 2 No 9 ☐ Unknown	eath 5 Other (specify)		
P.O.	sician: The law requires that the decentificate has been signed by the rector, page 2 should be detached	by Ph	Part II. Other significant conditions contributing to death but not resu	lting in the underlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?
	uires t n sign uld be	q pa			1 🗆 Yes	2 No 3 Probably 4 Vinknown
Š	w require bee	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Rec	The la ate ha page	l e			performed	? death?
<u> </u>	cian: ertific ector,	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Chec	ck only one)	
<u> </u>	Physi this c	<u>٩</u>	I Yes 2 INO Inpatient 2 I			6 Other (Specify)
0	ding l th. After funer	cate	1 Natural 5 Pending (Month, Day, Year)	28b. Time of 28c. Injury at work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred
Division of Vital Records,	Atten ar dea' ector: by the	ĬŢ.	3 Suicide 6 Could not be 28e. Place of Injury - At hon	ne, farm, street, factory, office		and Number or Rural Route Number,
Ο̈́	tal or rs afte al Dir	0	building, etc. (Specify)		City or Town, St	are)
	Hospi 24 hou Funer sted fil	Medical Certificate:	29a. Certifier 1 Certifying Physician: To the best of my knowle (Check 2 Medical Examiner: On the basis of examination	and/or investigation, in my opinion, death occurred a	at the time, date and pla	ace, and due to the cause(s) and manner stated.
	To the Hospital or Attending Physician : The law requires that the death certificate within 24 hours after death. To the Funeral Director : After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	ž	only one) 3 L Certifying Nurse Practioner: To the best of my 29b. Signature and title of certifier	knowledge, death occurred at the time, date and pla 29c. License number		se(s) and manner as stated. Date signed (Month, Day, Year)
_	⊢ ≶ ⊨ ō		I Thomas He Bridge MIL	1 14200		1/2/11
	7		30. Name and address of person who completed cause of death (Item:			104/
	31-1 VA		Thomas Brondo MD, VA N	largland Health Care Syst	em Perr	y Porty Md. 21902
	Sta Registr		31. Date filed (Month, Day, Year) / 32. Registrar's Signatu	A ha v	,	•
	negisu	e1	MANUU (UI Theune)	CI. IDAN		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Dale Lewis Gree	en	State of Maryland / Department of Certificate of Registrar		_	Reg. No. 201	1 01295
Physici Medical Exami		Decedent's Name (First, Middle,Last) Dale Lewis Green		2. Date of De Month January	ath	3. Time of Death 0045 hrs
		4a. Facility Name (if not institution, give street and number) Carroll Hospital Center	4b. City, Town, or Location of D		4c. County of De	
Funeral		5. Social Security Number 6. Sex 7. Age (In yes last highday)	Westminster If Under 1 Year If Under 24	4Hrs. 8. Date of B	Carroll irth(MM/DD/YYYY) 9. I	Birthplace (State or
Director		214-64-3456 _{1 M 2 F} 54 Yrs	Months Days Hours		_ / IFor	eign CountryPenna.
any		Usual Residence of Decedent 10a. State	on			10d. Inside City Limits
<u> </u>	ō	Maryland Carroll County New Winds	sor			1 Yes 2 No
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show natic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 1690 Wakefield Valley Road	10f. Zip Code 21776		10g. Citizen of What Co United Sta	•
n with the ms 23a		11. Marital Status 12. Was Decedent Ever in U.S. 13. Wa	s Decedent of Hispanic Origin?	(Specify Yes or No		erican Indian, Black,
ter deati	Funeral	1 Yes 2 X No	es, specify Cuban, Mexican, Pu	erto Rican, etc.)	White, etc.	
iours afi latural'	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Deceden	Yes 2 X No specify: t's Usual Occupation (Give kind	of work done	Specify:	
36 nin 72 h E. than "n dical E	Completed		ost of working life. DO NOT use C works employe		public wo	orks
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica		17. Father's Name (First, Middle, Last)		ame (First, Middle,	Maiden Surname)	
ID 2121 should be fi and Mental 77 is marked natic event,	To Be	J. Edward Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	_	n Dale		
MD d 2 shou lth and n 27 is	٦	Sandy L. Vleck / wife 1690°	Address (Street and Number Wakefield Vall	or Rural Route Nui .ey Road	mber, City or Town, Sta New Winds	ite, Zip Code) SO r, MD 21776
more, M Pages I and 2 ient of Health :		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 20b. Place of Disposic crematory or oth Carroll (tion (Name of cemetery, er place)	Date	20c. Location - City	
Baltimore, permit. Pages l a Department of He Important: If ite injury or other to		4 Donation 5 Other Specify:		2011		d, Maryland
	1 (4	Alen C. Turvi M01072 934	South Main St	reet Har	eral Home mpstead, Ma	aryland 21074
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.		ac or respiratory arr	rest, shock, or heart	Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death) a. Drowning complicated by Hypotherical Due to (or as a consequence of):	mia			Death
	ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last use to (or as a consequence of):				
- tra		d				
ਹ ਜ਼ੜ	Medical	UNPENDED x AMENDED 27,28 per me g IF FEMALE: 23c. If yes, outcome of pregnancy	912 2-/-11 vt			
Box 68760, e death certificate be the attending physic of for use as the buried for the buried for use as the	jan/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Feto	al death 3 Ectopic pre	gnancy	23d. Date of delive Month	Day Year
Box e death the atte	Physician/N	1 Yes 2 No 9 Unknown 9 Unknown	er (Specify)			
P. C. S. that s that gned a deta	<u>a</u>	Part II. Other significant conditions contributing to death but not resulting in the ur	nderlying cause given in Part I.		obacco use contribute to	
ords, P.C w requires that as been signed t	Completed			24a. Was	s 2 No 3 Pro	utopsy findings available
Division of Vital Records, rat or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	d Ho			_ autop perfor 1 ✔ Yes	prior to med? death?	completion of cause of
Vital Recc ysician: The lav his certificate ha director, page 2	B B	25. Was case referred to medical examiner? Hospital: 1 Innetient 3 PER (Outputient)	26.Place of Death (Che		2 No 1 V	es 2 No
n of Vit ding Physia After this funeral dire	٤	27. Manner of Death 28a. Date of Injury 28b. Time of the			Residence 6 Other	эг:
Sion Aftendia death. Ctor: A	atio	1 Natural 5 Pending FOUND: FOUND: Street Accident Investigation Jan 3, 2011 FOUND: 1 Natural 5 Pending FOUND: Province of the street of the st	1 Yes 2 ✔ No	Subject drow unknow	wned in frigid wate	er-
Division pital or Atten ours after death teral Director: filled in by the	Certification:	3 Suicide 6 X Could not be determined (Specify) Pond	, factory, office building, etc.	or Town, S	tate)	ural Route Number, City
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurre	ed at the time, date and place, a	ind due to the caus	e(s) and manner as sta	ted
To the Hos within 24 h To the Fur	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated. 29b. Signature and title of certifier	on, in my opinion, death occurre	d at the time, date	and place, and due to t	he cause(s)
		(X a los los MIN	29c. License number O.C.M.E.		29d. Date signed (Mo	
UN 5	-	30. Name and address of person who completed cause of death (Item 23a)			, ,, == ,,	
Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	timore Street, Baltimore	, MD 21223		
Registr		JAN 0 6 2011 Renun B. Jan	Ked			

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 201 Par JANUARY 2:13 Pm LOTOYA GRIFFIN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL CLINTON 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 😾 F Months Days Hours JAN 6 Pay 978 MARYLAND 32 Yrs. 217-90-6765 Director Usual Residence of Decedent ms 23a or 28a-f shov must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 ☐XYes 2 ☐ No PRINCE GEORGE'S TEMPLE HILLS MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20748 USA 6007 SAINT MORITZ DRIVE # Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Black, White, etc. Completed by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 No Specify. Specify 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) NONE DISABLED 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JOYCE GRIFFIN ROBERT TAYLOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20748 6007 SAINT MORITZ DRIVE #702 TEMPLE HILLS, MARYLAND JOYCE GRIFFIN/MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date □XBurial 2 □ Cremation 3 □ Removal from State 1/13/2011 LANDOVER, MARYLAND HARMONY CEMETERY 4 Donation 5 Other (Specify) J. B. JENKINS FUNERAL HOME, INC. 22. Name and Address of Facility eral Service Licenses 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ M123:00 Medical resulting in death) Due to (or as a consequence of) Examiner erebral Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: Uve Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) ed by the g Unknown ate has been signed by page 2 should be detac Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? ☐ Yes 2 No this certificate 1 ☐ Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Inpatient 2 K ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural Hospital or Attending work? 5 Pending 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 7 to the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 01/01/11 D64055

cf 4

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 4, 2011 4:40 p M Nathaniel Holland Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Calvert County Nursing Center Prince Frederick Calvert Social Security Number Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs Months Days Hours Min. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Yea Director une 14. MĎ 82 212-24-4068 Usual Residence of Decedent shov 10a. State 10d. Inside City Limits 10c. City, Town or Location Examiner must be notified at Director 28a-f 1 🗌 Yes 2 🕱 No MD Calvert Sunderland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 7175 Dorothy Drive 20689 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. ģ 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: "natural" Completed 3 Divorced 4 Divorced Black Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Mental Hygiene. larked other than Elementary/Seconday (0-12) College (1-4 or 5+) the Lumber Company Truck Driver traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္ရ Lola B. Emerson Edward Holland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau 7175 Dorothy Drive, Sunderland, MD 20689 Philander Holland - son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Ernestine Jones Cemetery: January 10, 2011 Chesapeake Beach, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Sewell Funeral Home, P.A. Bladen 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a Atheroscienotic (ordiovascular chiease disease or condition Medical resulting in death) Examiner ypertensive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death 2 🗌 No 9 Unknown 9 Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 ☑ No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Matural 5 Pending 2 No 1 Yes Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) D 50653 1-6-2011 eyan . C. om arc C. SURANA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GVAN church for Deale 32. Registra State JAN Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 0330 AM 00 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Prince Frederick Calvert Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours Director 2/18/1940 236-62-8565 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, "he Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo MD Calvert Huntingtown 1 Yes 2XXNo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 3421 Bayside Forest Court 20639 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Fire Protection Fire Protection Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be filk h and Mental F 7 is marked o ည Roy Titus Hill Annabel Karr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Nancy Hill/Spouse 3421 Bayside Forest Court, Huntingtown, MD 20639 permit. Page 1 and 2 Department of Healtt Important: If item 23 any injury or other th 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 01/10/2011 4 Donation 5 Other (Specify) Clinton, MD Lee Crematory Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. Lisa M. Mounts Md Blvd., Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician/ Preum orcio Medical Due to (or as a consequence of) Examiner COPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last eems Vorax and Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, the Hospital or Attending Physician: The law requires 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 🗌 Yes 2 🗐 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No ည 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral or 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D006178 3 2011 61 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chang M.D. 100 Hospital Road, Prince Frederick, MD 20678 31. Date filed (Month, Day, Year) 32. Registra s Signature JAN Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month KERMIT HAYDEN JR. ROBERT **JANUARY** 2011 10:02A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PLATA CHARLES CIVISTA MEDICAL CENTER 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 X M 2 🗆 F 220-26-6494 MD mirry) 81 Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD. CHARLES LA PLATA 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral P.O.BOX 488 20646 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. or 1 Never Married 2X Married Completed by 2 X No Baltimore, Maryland 21215-0036 ☐ Yes 1 Yes 2 X No Specify: Specify:WHITE If Yes. Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry
LA PLATA GLASS (Specify only highest grade completed) 72 and Mental Hygiene. Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) AUTO GLASS SHOP OWNER 10th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ROBERT KERMIT HAYDEN, SR. ANNIE MAE RICE 19a. Informant's Name/Relationship (Type, Print)
MARY ANN HAYDEN-SPOUSE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\dot{P} \cdot O \cdot BOX 488 \quad LA \; PLATA, MD \cdot 20646$ 1 and 2 s of Health item 27 i injury or other 20b. Place of Disposition (Name of cemetery crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot Date Burial 2 X Cremation 3 Removal from State Crematory or other practer (Specify)

METROPOLITAN CREMATORY 1-16-11 ALEX., VA. 21. Signature of Financial Service Licensee M00479 2. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. 5635 WASHINGTON AVE., LA PLATA, MD 20646 23a. Part 1. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Ph sician/ THERO EROT disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consequence of: Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PERTENSION 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown Completed FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate has autopsy performe CANCER PROSTA 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A 2 Accident
3 Suicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined building, etc. (Specify) Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in his opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier D0026064 01-11-201 101

Registrar DHMH 17 Rev 7/2009

State

10583 THEODORE GREEN BLVD WHITE PLAINS MD

M.D

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VIDYASAGAR ANMANGANDLA,

JAN 20 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Physician/ Month JAMuai Year 1933 M SUSAN ELAINE HALLETT Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospital Easton Memorial Talbot 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 12/23/1948 **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🛛 F Days Hours NEW YORK Director Yrs 076-40-6906 62 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director WESTCHESTER 1 Yes 2 X No **NEW YORK** PEEKSKILL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3 WOODS CIRCLE, APT. K 10566 **USA** 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 th and Mental Hygiene.
27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) LAW **PARALEGAL** 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev ျ ROBERT W. HALLETT ALICE M. VAN RENSSELAER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANDREA L. ALDUINO / NIECE 808 WRIGHTS NECK RD., 808 WRIGHTS NECK RD., CENTREVILLE, MD 21617 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place MID SHORE CREMATION CENTER BY 4 Donation 5 Other (Specify) 01/05/2011 CAMBRIDGE, MD COLLEEN CURRAN-BROMWELL, P.A. 21. Signature of Funeral Ser 22. Name and Address of Facility CURRAN-BROMWELL FUNERAL HOME, P.A., 308 HIGH ST., CAMBRIDGE, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Orset and Death Ph sician/ disease or condition resulting in death) Medical Due fo (or as a consequence of) Examiner reumma Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying ue to (or as a consequence of) the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy pade 2 perform Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 XNo Other: မ 1 Anpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred s after death. work? 1 ☐ Yes 2 ☐ No. Natural 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2011

Registrar

State

S. Was hortons

219

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N

52. Registrar's Signature

W. Morto

06

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible/Ink/ Ensure All Copies Are Legible.
Amend Tem 21 in Black Indelible/Ink/ Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2011 Month Physician/ 5:30 P M January Medical <u> Isabelle</u> Hart 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** <u>Washington</u> <u>Julia Manor Health care Center</u> 9. Birthplace (State or Foreign Country) Maryland 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 😾 F Director 79 219-54-0877 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and the files 23a or 28a-f show and the filem 27 is marked other than "natural", or items 23a or 28a-f show ury or other traunatic event, the Medical Examiner must be notified at ury or other traunatic event, the Medical Examiner must be notified at. 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 X Yes 2 No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 333 Mill St. 21740 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. ģ 1 X Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: If Yes, Give Specify: Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 8 th College (1-4 or 5+) Residential th Housekeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Clara Belle Mills Harry Adams Hart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. Joseph A. Hart <u>/ Brother</u> 3047 Resh Road, Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/12/2011 Hagerstown, MD Cedar Lawn Memorial Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gerald N. Minnich Funeral Home Bryan K. Kenworthy , Hagerstown, MD 21740 Potomac St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final Ph_sician/ Chronis Obstructive Pulmonary Disease disease or condition resulting in death) Medical Examiner Due to (or as a consequence of Asthma Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Pulmonary Hypertension that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Cardiomyopathy Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 Other (specify) been signed by the a should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Dementia, Morbid Obesity 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛛 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I; page 2 s autopsy performed After this certificate funeral director, pag 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2XXNo 26. Place of Death (Check only one) Be Other: 4 😾 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation within 24 hours after death

To the Funeral Director: A

completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 3. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R125360 January 7, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barbara Naden-Blucher, CRNP 333 Mill Street, Hagerstown, MD 21740 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10e&19b Per FH G912 2/18/2011 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20 11 Month Hearner Lee 8:03 AM Januar Medical 4a. Facility Name (if not institution, give street and number) 4b City, Town, or Location of Death Examiner 4c. County of Death Atlantic General Hospital Worcester 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 1 M 2 F Months Days Hours Min. Country **Director** Yrs 216-30-3141 Feb. 1935 Maryland Usual Residence of Decedent show 10a State 10b. County notified at 10c. City. Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 No DE Sussex Selbvville b 34341 West Line Road 10f. Zip Code 10g. Citizen of What Country? nt of Health and Mental Hygiene.

If item 27 is marked other than "natural", or items 23a or or other traumatic event, the Medical Examiner must be I Funeral 341 W. Line Road 19975 U.S.A. death 12 Was Decedent Ever in LLS 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. 3 ₩ Widowed 4 □ Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Seamstress Textile Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John W. Mabel Row 19a. Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sł Department of Health a Important; If item 27 ls any injury or other tra Brenda L. Tomlinson / Daughter | 341 Selbyville, Delaware 19975 Road, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Lawn Memorial 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jan. 8, 2011 Hagerstown, MD 21. Signare of Funeral Service Ligensee 22. Name and Address of Facility Rest Haven Funeral CHapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ructive MODIC 551 pulmonary Pars disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of). Examin and burial-trar Due to (or as a consequence of): inding physician ause as the burial-Physician/Medical pe Box 68760 IF FEMALE asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown for 4 ☐ Pregnant at time of death g ☐ Unknown Day Year been signed by the s should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaçco use contribute to the cause of death? þ Records, mass Completed 1 Yes 2 No 3 Probably 4 Unknown diabetes mellits De 24a. Was an 24b. Were autopsy findings available page 2 has prior to completion of cause of death? autops, performed Dertersion certificate 2 4 No Yes 1 Yes Vital 25. Was case referred to medical or Attending Physician: æ 26. Place of Death (Check only one) examiner? Hospital 1 Tes 2 1 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner eath 28b. Time of 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Watural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation within 24 hours after deat To the Funeral Director: completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 [] 3 [] To the only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier C1-0006795 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lighthouse Road, Selbyville, 05H-1 31. Date filed (Month 32. Pegistrar's Signature State 0 Registrar

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John Kenneth Ho			ate of Maryla	and / Dep		f Health a		Hygiene	201	1.01303
Physicia	n/	Decedent's Name (First, Midd	e,Last)					2. Date of Dea	ath	3. Time of Death
Medical Examin	ıer	John Kenneth 4a. Facility Name (if not institution		mber)		4h City Town	or Location of De	Month January 1	10, 2011 4c. County of	0640 hrs
		Ft. Washington Hospi				Fort Was		, , , ,	Prince Ge	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Y				9. Birthplace (State or
Director		255-11-3603	1XM 2F	35	Yn		ays Hours I	July 2	6, 1975	Foreign Country) Virginia
any		Usual Residence of Decedent 10a. State 10b. County		I10c City	y, Town or Loca	ion		<u> </u>		10d. Inside City Limits
ا ع		Maryland Char	عما	1,55,51,	Waldor					1 YYYY 2 No
arylan	윷	10e. Street and Number	103		Waldol	10f. Zip Code)		10g. Citizen of Wha	7.77
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leath with	era	11. Marital Status 1 Never Married 2 X Ma	12. Was Dec	edent Ever in U	J.S. 13. W	s Decedent of I		Specify Yes or No		American Indian, Black,
er deal			1 Yes	2 X No						White
urs aft tural"	호	15. Decedent's Education (Spec	or Dates:		16a. Decede	Yes 2 X I	oation (Give kind	of work done	16b. Kind of Busi	
7 3 7	e e	Elementary/Secondary (0-12)	College (1		during n	ost of working I	ife. DO NOT use	retired)		
21215-0036 Uld be filed within 72 hours at Mental Hygiene. marked other than "natural creent, the Medical Examin	Completed	11th.			Self	Employe				roofing
of filed all Hyg	Be C	17. Father's Name (First, Middle, Ronald L. Hott	Last)					me (First, Middle,		
	의	19a. Informant's Name/Relations	nip (Type, Print)		19b. Mailin	g Address (Str	eet and Number	<u>ä R. Gro</u> or Rural Route Nur	ves mber, City or Town,	State, Zip Code)
MD d 2 sho lith and n 27 is		Jeanne Arlene H	lott/ Wife		9380	rances	Street,		, Marylan	nd 20603
ore, M	П	20a. Method of Disposition 1 Burial 2 X Cremation	3 Removal fro	20b.	Place of Dispos crematory or ot	ition (Name of oner place)	cemetery,	Date	20c. Location - C	City or Town, State
Baltimore, permit. Pages 1 a Department of He Important: If ite	Ц	4 Donation 5 Other Sp	ecify:		lantic	Cremato	ry Jar	16, 20	11 Glen F	Bernie. MD.
Baltimo permit. Page Department o Important: injury or oth	П	21. Signature of Funeral Service	bicensee	10 . 0	22.1	lame and Addre	ess of Facility H	untt Fun	eral Home	
Physician	1	23a. Part I. Enter the disease, or		used the death	n. Do not enter t	ne mode of dyin	<u>Vashing t</u> g, such as cardia	on Rd. Wa c or respiratory arm	aldorf, M est, shock, or heart	D. 20601 Approximate Interval
/Medical	-	failure. List only one cause Immediate Cause (Final disease		ne and	Methado	ne Into	xicatio	n		Between Onset and Death
Ēxaminer	-	or condition resulting in death)	Due to (or as a							
	ᅵᇦ	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of	of):					
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		events resulting in death) Last	Due to (or as a d.	consequence o	or):					
be executed incian and urial - transit	Physician/Medical	X UNPENDED		23a,27,	,28a-f j	er me g	g913 3-2-	-11 vt		
Box 68760, a death certificate be the attending physici of for use as the buri	ٳڰۣ	IF FEMALE: 23b. Was decedent pregnant in th	23c. If yes, o	outcome of preg		tal death 3	Ectopic preg	manov	23d. Date of de Month	elivery Day Year
x 68 th certi	<u> </u>	past 12 months?	4 Pregna	ant at time of de	anth -	ner (Specify)		griancy	Wiorita	Day real
be dea y the a hed fo	چ	1 Yes 2 No 9 Unk Part II. Other significant conditi	nown 9 Unkno		It' ' th	4.4		DO- Bide		
ires that the signed by I be detach	≥	ran ii. Outer significant condu	ons contributing to	death but not r	esulting in the u	nderlying cause	given in Part I.			ite to the cause of death? Probably 4 Unknown
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Division of Vital Records, tal or Attending Physician: The law require attendenth. In Sirector: After this certificate has been sided in by the funeral director, page 2 should be difficultion. To Be Commissional	힐		···			_			med? dea	or to completion of cause of ath?
tal Reco		25. Was case referred to medical	T			26.Pla	ce of Death (Chec	1 Yes	2 No 1	Yes 2 No
Vital I hysician: this certifi I director,	o n	examiner? 1 ✓ Yes 2 No	Hospital: 1 Ir	npatient 2	ER/Outpatient	-	Othor: -		Residence 6	Other:
ling Ph After t funeral		27. Manner of Death 1 Natural 5 Pendi	28a. Date ((Month,	of Injury Day,Year)	28b. Time of I	njury 28c. Inj	ury at Work?	28d. Describe t	now injury occurred	
Attend r death ector: by the	Ĭ	_ Pend	tigation	10-11	fd 5:30	-	Yes 2 X No	unknow		
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5 - 3 >	- 1	20a Cartifier	ysician: To the best			ed at the time,	date and place, a	·		
To the Hos within 24 h To the Fun completely		one) 2 Medical Exam	niner:On the basis o and manner st		nd/or investigat	on, in my opinio	on, death occurred	d at the time, date	and place, and due	to the cause(s)
2	Σ	29b. Signature and title of certifier	-1.				se number	00115		(Month, Day, Year)
		Theodore.	m. The	Y TR.	med	0.0	.M.E.	OGME	January 11, 2	2011
3		Name and address of person of Theodore M. King, Jr.,			,	000 W. Balti	more Street.	Baltimore, MD	21223	
Stat	_	31. Date filed (Month, Day, Year)	2. Reg	gistrar's Signatu	ure .					
Registra	:17	JAN 18 20	177 Sener	N B.	park.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month O HOLLENBACH 2:39 a M 02 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Rose Haven 7026 Boston Avenue Conne arundel Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 M 2 D F (Month, Day, Year) 09/08/1950 115-40-1090 Months Days Min. 60 **Director** Usual Residence of Decedent 28a-f show 10a. State Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD 1 🗌 Yes 2 🙀 No Anne Arundel Rose Haven 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral BOSTON 20714 7026 USA Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces? Black, White, etc 1 Never Married 2 Married 2 Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: WHITE Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Construction Construction Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be a Department of Health and Ments Important: If item 27 is marked Eleanor Pauline Stanwycks Frank Jacob Hollenbach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Hollenbach/Wife 7026 Boston Ave., Rose Haven, MD 20714 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 01/05/2011 Lee Crematory Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert Lisa M Mounts 8125 Southern Md Blvd., Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) MINIO SCLENOTIC CALDIOVASCUM BISLASI Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence or) Hospital or Attending Physician; The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): ending physician a use as the burial-Completed by Physician/Medical Box 68760 IF FEMALE: 23c, If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signe should be d Records, 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 🗌 Yes 2 🗌 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Z Natural 5 Pending within 24 hours after death.

To the Funeral Director: At completed filled in by the fu Accident 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie s of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addres ARW J. WISNIEWSKI TTANLEY 31. Date filed (Mohth, Day, Year) 32- Registraris Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Clark Hoffman, Sr. William 1:45 P M 2011 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 16103 Mountain Ridge Road Rawlings Allegany Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗀 Months 08/03/1936 Director 219-32-2240 Pennsylvania Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at pernit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Rawlings 1 🗌 Yes 2 🗓 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 16103 Mountain Ridge Road 21557 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married ğ Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Freight 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sarah Flavious Hoffman Matilda Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16103 Mountain Ridge Rd, Rawlings, MD 21557 Betty J. Hoffman / Wife Baltimore, Important: If item any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State Cumberland Crematory 01/04/2011 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) Signatura of Funeral Service Licenses 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical s a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the luneral director, page 2 should be detached for use as the bunal-transit Wasive Cause (Disease or linjury Due to for as a consequence of). resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No Hospital Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 X Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 1 🔼 Natural injury 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier -oni) 3rd 2011 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Nagaratnam 4. Ranjithan, M.D., 517 Oldtown Road, Cumberland, MD

Registrar DHMH 17 Rev 7/2009

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State

31. Date filed (Month, Day, Year)

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32 Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month **GEORGE** RAYMOND HUDSON 2235 M 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death eairmal Medical (enter If Under 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 XM 2 □ F Months Hours JULY 9, Year 948 Director 221-28-6800 62 Vrs DELAWARE Usual Residence of Decedent 28a-f show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🛛 No DELAWARE SUSSEX FRANKFORD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 37013 JOHNSON ROAD 19945 USA 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc 9 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates. 1966-93 1 ☐ Yes 2 XNo Specify: WHITE 3 Widowed 4 Divorced Specify: Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than ' life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) CHIEF STOREKEEPER US COAST GUARD Be and 2 should be filed a Health and Mental Hyg 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) 2 RAYMOND H. HUDSON HTT.DA LONG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. SANDRA K. HUDSON/WIFE 37013 JOHNSON RD., FRANKFORD, DELAWARE 19945 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 🕏 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town. State CREMATORY OF DELMARVA 4 Donation 5 Other (Specify) 1/8/11 DELMAR, DELAWARE 21. Signature of Financial Service Licen 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician Ischemic Cardionyo disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ASCUD Sequentially list conditions, Examine as a nunsecurings of if any leading to immedi cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and the burial-trai Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Yea signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown peen Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy 1 Yes 2 No Yes funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 Other: ျှ 1 🔲 Yes Inpatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, uearn occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) DO lt0056197 2010

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month O Physician/ Day 05 7:30 PM Jackson Markwood JENKINS Sr Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 735 Spruce Street Hagerstown Social Security Number 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1**X** M 2 □ F Hours Country) 220-26-0715 Yrs **Director** 80 Dec. 6 1930 Mary Land Usual Residence of Decedent 28a-f shov filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland 1 🏝 Yes 2 🗆 No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 735 Spruce Street 21740 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married δ Yes 2 x No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) mechanic automotive/trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev once. Emmett Markwood Jenkins Bessie Dennis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris J. Jenkins - wife 735 Spruce St., Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔣 Burial 2 🗌 Cremation 3 🗀 Removal from State Rose Hill Cemetery 1/8/11 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ ADENOCARCINOMA disease or condition resulting in death) MC BOTH Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Examir To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Year Pregnant at time of death After this certificate has been signed by the funeral director, page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Atherosciercitic Cardiovascular Disease Completed 1 Yes 2 No 3 Probably 4 Unknown HYPERLIPIDEMIA 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.
Funeral Director: After thi leted filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 No Accident Investigation Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

within 2. 10

State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STOURN BLASH, WD

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29d. Date signed (Month, Day, Year)

JANUARY 7 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20^{Year} Cleola Victoria Johnson Medical 4:45 AM January 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Berlin Nursing & Rehabilitation Ctr. Worcester Berlin Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland 1 □ M 2 🛣 F Months Days Hours Min. March 14 **Director** 214-34-5004 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Dorchester Cambridge 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1232 Chesnut Place, Apt. 101 USA 21613 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married 1 Yes 2X No If Yes, Give Year or Dates. Black, White, etc. Johnson Cleol Baltimore, Maryland 21213-0036 1 ☐ Yes 2 ☒ No Specify: Completed Specify: Black 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 11th Laborer AirPax Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ William Henry Dennis Nellie Elizabeth Manuel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21613 Cleopatra Young/ Daughter 1232 Chesnut Place, Apt. 101 - Cambridge, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State ₩ Burial 2 Cremation 3 Removal from State 4 ☐ Denation 5 ☐ Other (Specify) New Macedonia Bapt. Ch Cem. 01/08/2011 Pocomoke City, MD 22. Name and Address of Facility 1213 Jersey Road, Salisbury, MD of Funeral Service Licensee IOLLEY MEMORIAL 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine accident the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Cular attending physician and I for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month signed by the at d be detached for Pregnant at time of death Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: 2 🗆 No Yes 2 X No 1 Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ၉ 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XNatural work? 5 Pending 2 No hin 24 hours after death the Funeral Director: Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one Certifying Nurse/Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within To the 29b. Signature and the e of certifier 29d. Date signed (Month, Day, Year) R 135131 January 3, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pennie Savage, CRNP 9715 Healthway Dr, Berlin, MD 21811 State Registrar's Signate Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fh g911 1-20-11 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Gary Patrick Jordan, January 10, 2011 1:50 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Golden Living Center Hagerstown Washington 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Director 218-24-9470 78 3/17/1931 Maryland Usual Residence of Decedent 10d. fnside City Limits 10a. State 10b. County 10c. City, Town or Location *how r than "natural", or items 23a or 28a-f shortte Medical Exp. dran crast be notified at 1 Yes 2 No Director MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 750 Dual Highway 21740 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritaf Status filed within 72 hours after Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) Coflege (1-4or 5+) Radio Operator 12 U.S. Army of Health and Mental Hygie fitem 27 is marked other t r other traumatic event, # 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Pages 1 and 2 should be fil ment of Health and Mental H tant: If item 27 is marked ott Ernest Porterfield Jordan Nina Irene Goetz 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 844 Sumo Ave., Florence, Colorado 81226.

Date 20c. Location - City o Tim Jordan / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6 permit. Page Department of Important: If any injury or once. 1-14-11 Smithsburg, Maryland Smithsburg Crematory 21. Signature of Funeral Service Dicensee Rest Haven Funeral Chapel 22. Name and Address of Facility 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) **Physician** Chonau arten MINS /Medical Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (c) as a consequence of Examine The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atte in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š cete hes been sig. , page 2 should b 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☑ No 24a. Was an autopsy performed? res 2012 No this certificate 1□ Yes or Attending Physician: Director: After this certific in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of fnjury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 10 Naturaf death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ក់ To the Hospitel o within 24 hours eft To the Funeral Di completely filled 29a. Certifier 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 028365 1-10-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HURDY 368 Street mull 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 20 2011 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Mary		artment of F rtificate of			giene	Below to the B	01310
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r A	/Medi Exami		4a. Facility Name (If not institution, gir CRESCENT CITIES		VTER	4b. City, Town, o	r Location of Death LE		4c. County PRINC		RGE'S
	Funeral Director			Sex 7. Age (In 1	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da AUG. 2	y, Year)	9. Birthp Cour JAMA	place (State or Foreign htry)
	and w		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	cation					
	Aaryta f sho	ō	MD PRINCE (RIVERDA						10d. Inside City Limits 1 □ Yes 2 □ No
	288-	Director	10e. Street and Number	ZEORGE B	KI V BRDII	10f. Zip Code			10g. Citizen of	What Cour	21
	death with the Maryland ms 23a or 28a-f show	al D	6202 60TH AVENUE			20737			USA		,
960	ours after rail, or ite	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			lispanic Origin? (Sp an, Mexican, Puerto Specity:	ecify Yes or No Rican, etc.)	- 14. Rad	ck, White,	can Indian, etc. ACK
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Baltimore,	ges 1 and 2 it of Health if item 27 or other tre		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □	Removal from State	Ob. Place of Dispos		1	Date	20c. Location		
Iţi	it. Pa rtmen rtent: njury		4 Donation 5 Other (Special Signature of Funeral Pervio Lice	- 33	EVERDALE			/2011	RIVERDA	ALE,M	ARYLAND
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.O. Box	that the death certif ed by the attending detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ √o 9 □ Unknown	23c. If yes, outcome of pro 1 ☐ Live birth 2 ☐ If 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3 🗌	Ectopic pregnancy Other (specify)				te of delive	ory Day Year
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Vita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		Othe	26. Place of Death	Check only or	n <i>e</i>)		
o	Phys er this eral di	5. To	1 ☐ Yes 2 🕅 No 27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatient 28b. Time of		4 X Nursing Ho		tence 6 Oth		"
io	Attanding r death. sctor: After by the fune	atloi	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		r) Injury	28c. Injury Work	res 2 □No		,,,		
Division	d or Atter after de Directo d in by th	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - / building, etc. (Sp	At home, farm, stre	et, factory, office		28f. Location (S City or Tow	Street and Numb in, State)	er or Rura	l Route Number,
	To the Hospital or Attanding Physician: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exar	ysician: To the best of my niner: On the basis of exam and manner stated.	knowledge, death nination and/or inve	occurred at the timestigation, in my op	ne, date and place, a pinion, death occurre	and due to the o	cause(s) and ma	inner as st	ated. the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	and married stated.		29c. License	number		29d. Date signer	d (Month, i	Day, Year)
			Hund	Q. () Qu	In G	D018	35 <i>2</i>		JANUAR	y 2.	2011
R	5		30. Name and address of person who PAUL A. DEVORE	completed cause of death (M.D. 4203 QU	(Item 23a) (Type, P EENSBURY	rint)		,MARYLA			
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 7 2011	32. Registrar's	nature	17/0					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Item 2 & State of Maryland / Department of Health and Mental Hygiene State Registrar 29d WCHD/SH 1/11/11 per Dr. Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) Date of Death 01/05/2011 3. Time of Death Physician/ BETTY JANE 11:39 PM KELLER . Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MERITUS MEDICAL CENTER HAGERSTOWN WASHINGTON Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛛 F Months Days 220-18-3371 Hours ADril Day Mary Land Director Usual Residence of Decedent 28a-f shov 10a, State 10b. County be filed within 72 hours after death with the Maryland 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington County Hagerstown 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20212 Jefferson Blvd. 21742 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 X Widowed 4 □ Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Personal Residence Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ဂ Lewis Hillard Staley Kathryn McAllister Staley permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard A. Keller-son 13703 Franks Run Rd. Smithsburg, MD 21783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Rest Haven Cemetery 1-10-2011 | Hagerstown, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A, Fiery Funeral Home Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ ACUTE disease or condition MYOCARDIAL Medical resulting in death) Due to (or as a consequence of) Examiner HAPERTENSIO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events MANY YEARS Examiner Due to for as a consequence on To the Hospital or Attending Physician; The law requires that the death certificate be executed YEARS FAILURE CONGESTIVE HEART and -tran Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year signed by the a d be detached f g Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s performed? Yes 2 No certificate 1 Tes 2 🗌 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No 1 Yes Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 24 hours after death.
Funeral Director: After this leted filled in by the funeral di 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No. Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

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State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year

13424

M.D

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Pennsylvania

00041234

29d. Date signed (Month, Day, Year)

101

01/06/2011

21742

MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death onth O1 Physician 201^{Year} **03** JAMES RAYMOND KOHLHAUS 10:25 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **ENVOY OF DENTON** DENTON CAROLINE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days 1 X M 2 □ F 89 220-05-1397 07/04/1921 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 X Yes 2 No MD CAROLINE DENTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 420 COLONIAL DRIVE 21629 UNITED STATES Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1944þ 1 ☐ Yes 2 X No Specify. 3 XWidowed 4 ☐ Divorced Specify: WHITE 1945 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 MECHANIC AUTOMOTIVE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ RAYMOND KOHLHAUS FRANCES McEVOY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CLIFFORD J. KOHLHAUS/SON 521 WYE MILLS ROAD, QUEENSTOWN, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State WOODLAWN MEMORIAL 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 01/07/2011 EASTON, MD **PARK** 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON ST., EASTON, MD 21601 NOHN MERCERON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EMENTIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HEROS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes perform 2 No 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 Yes 2√ No Other: Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 □Pending Investigation 1 Natural 1 🗌 Yes 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Physician/Medical þ Be Completed

29a. Certifier

(Check only one)

The law requires that the death certificate be executed physician and s the burial-trans ģ certificate has b rector, page 2 s Hospital or Attending Physician: funeral dir 124 hours after death.

• Funeral Director: /

Division or Vital Records, P.O. Box 68760,

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anone.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

To the within 24 TLS 6+VA

State Registrar

Medical

29b. Signature and alle of certif

29c. License number

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 20^{Year}1 9:45 am Fred Allen Keplinger January 4b. City, Town, or Location of Death Elkton 4a. Facility Name (If not institution, give street and number) 4c. County of Death 37 Pine Bluff Lane 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8-11-1927 9. Birthplace (State or Foreign Months Days Hours Min. 234-40-3301 Pennsylvania 83 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Cecil Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21921 USA 37 Pine Bluff Lane 12. Was Decedent Ever in U.S. Armed Forces?

12 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Affiled Folces:

1½ Yes 2 □ No

If Yes, Give

Year or Dates: 1947 1 Never Married 2 Married 1 ☐Yes 2 ZNo Specify: Specify: white 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Transportation Owner Trucking Company 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James A. Keplinger Glona Florence Harman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 221 Jeffrey Drive, Middletown, DE 19709 Patricia Chambers/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 1-14-2011 Franklin, WVA Kline Cemetery 4 ☐ Donation 5 ☐ Other (Specify) DANIELS & HUTCHISON FUNERAL HOME, LLC. 1242 N. Broad St., Middletown, DE19709 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each to e. Approximate Interval Between Onset and Death Immediate Cause (Final CHADNIC OBSTRUCTUE AIRUA DISIEASE disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consectionout) if an cause. Enter Underlying Cause. (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only on-Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and attending physician ass for use signed by i page 2 should

Division of Vital Records, P.O. Box 68760,

and burial-trai funeral

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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Items 23a

and Mental Hygiene.

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Department of Health a
Important: If item 27 is
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Physician

/Medical

Examiner

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Director

Funeral

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Completed the Medical

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Examine

Physician/Medical

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Completed

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Certification: To

Medical

29a, Certifier

(Check only one)

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

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		_		

2 Accident 6 Could not be determined 3 Suicide 4 Homicide

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

FLKNN MD 21921

29b. Signature and title of certifier

MD

29c. License number D3065733 29d. Date signed (Month, Day, Year) 10/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAD V. PULA, E. MGH

NARAMANA 31. Date filed (Month, Day, Year)

32. Registrar's Signature

126 A

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State Registrar

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within 24 hours a To the Funeral D

Box 68760

Records, P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

Physician
/Medical
Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exemitment or profiled at

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	1 - State Registrar	or Maryland / De	Certificate of I		Reg. N	2111	01315	
an	Decedent's Name (First, Middle, Last)				2. Date of Death Month D	ay Year	3. Time of Death 3:00 PM	
al	Kevin Andrew King		1		/1/2011		М	
er	4a. Facility Name (If not institution, give street and	number)		Location of Death		c. County of Death		
	35191 Betty Court 5. Social Security Number 6. Sex	7. Age (In yrs. last birthd		If Under 24 Hrs.	B. Date of Birth (Month, Day, Yea		place (State or Foreign	
	218-58-2775	F 52 Yrs	Months Days	Hours Min. 2	(Month, Day, Year /11/58	mD Cour	ntry)	
Į.	10a. State 10b. County	10c. City, Town or				1	0d. Inside City Limits 1 ☑Yes 2 ☐ No	
ecto	MD Wicomico 10e. Street and Number	Pittsvil	1e 10f. Zip Code		100.0	Citizen of What Cour		
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Jera	35191 Betty Court 11. Marital Status 12. Was D	Decedent Ever in U.S. 1	21850 13. Was Decedent of H	ispanic Origin? (Spec	US.	A 14. Race - Americ	can Indian,	
by Fur	1 Never Married 2 Married 1 Yes,	d Forces? es 2 📉 No , Give or Dates:	If Yes, specify Cuba 1 □Yes 2★ No	n', Mexican', Puerto Ri Specify:	ican, etc.)	Black, White, Specify: Wh	etc. ite	
eted	15. Decedent's Education (Specify only highest grade complete	16a. De	live kind of work done o	edent's Usual Occupation 16b. Kind of Busing kind of work done during most of working				
Be Completed by Funeral Director	Elementary/Secondary (0-12) Colleg	ge (1-4or 5+) Che	fe. DO NOT use retired		res	taurant		
	17. Father's Name (First, Middle, Last)			18. Mother's Name (,		
မ	Stephen J. King	1 491 44		Mary Made				
	19a. Informant's Name/Relationship (Type. Print) Jane King / wife		lailing Address (Street			·	Code)	
	20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from	20b. Place of Di	91 Betty Co isposition (Name of crematory or other place			D Z1850 Location - City or To	wn, State	
	4 □ Donation 5 □ Other (Specify)	1st Sta	ate Cremato			sboro DE		
	21. Signature of Funeral Service Liceogee	le	22. Name and Address 108 Willia				me	
ər	Sequentially list conditions.	to (or as a consequence of):	more	Jack as cardiac or	тезриатоту апезі,		Approximate Interval Between Onset and Death	
Completed by Physician/Medical Examiner	that initiated events	to (or as a consequence of):						
nysician/M	in the past 12 months?	outcome of pregnancy ive birth 2 Fetal death regnant at time of death nknown	3 ☐ Ectopic pregnance 5 ☐ Other (specify) _	/	23d. Date of delive Month			
S P	Pat II. Other significant conditions contributing to	o death but not resulting in th	e underlying cause give	en in Part I.	23e. Did tobacco	use contribute to the	ne cause of death?	
ed	Markon Vol	sur also			1 Tes	2 No 3 Prot	pably 4 nknown	
omple	-				24a. Was an autopsy performed?	prior to co death?	psy findings available mpletion of cause of	
Be	25. Was case referred to medical examiner?			26. Place of Death (7			
	1 Yes 2 No Hospital: 1	☐ Inpatient 2 ☐ ER/Outpa		er: 4 Nursing Home	e 5 Residence	6 ☐ Other (Specif	(y)	
ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ate of Injury Month, Day, Year) 28b. Tim Injur	ry Work	y at 28 ?? Yes 2 □ No	3d. Describe how inj	ury occurred		
Medical Certification: 10	3 Suicide 6 Could not be determined 28e. Pla	ace of Injury - At home, farm, uilding, etc. <i>(Specify)</i>	, street, factory, office	28	Bf. Location (Street a City or Town, Sta		al Route Number,	
dical (29a. Certifier (Check only one) 1 CertifyIng Physician: To 2 Medical Examiner: On the and m	the best of my knowledge, do ne basis of examination and/o nanner stated.	leath occurred at the tir or investigation, in my o	ne, date and place, ar pinion, death occurred	nd due to the cause d at the time, date a	(s) and manner as s nd place, and due to	stated. the cause(s)	
Me	29b. Signature and title of confirer	A.,	29c. License	number	29d. D	Date signed (Month,	Day, Year)	
	30. Name and address of person who completed c	ause of death (Item 23a) (Ty	pe, Print)	10001	5 0	11041	2511	
7 e	31. Date file (Month, Day, Year) 32	2. Registrar's Signature	YUS FARK	va I have)~	537 m	0 21804	

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month $20\overset{\mathsf{Year}}{11}$ 4:16 PM John Cornelius Kievit Medical January 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Cecil 17 Norway Court Elkton Social Security Number 9. Birthplace (State or Foreign Country) New Jersey 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** 1 X M 2 □ F Days Hours Min. Months 1930 Director 80 Yrs 146-22-1895 May 6, Usual Residence of Decedent 28a-f shov 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director r than "natural", or items 23a or 28a-f s the Medical Examiner must be notified 1 Tes 2 X No Maryland Cecil Elkton 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21921 United States 17 Norway Court death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Management Chemical Ith and Mental Hygie 27 is marked other r traumatic event, tl Be 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname, ဂ Department of Health and Menta Important: If item 27 is marked any injury or After John Cornelius Kievit Jessie Mae Marsh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 767 Bullville Rd., Montgomery, NY 12549 Robert Kievit Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 07-A2011 20c. Location - City or Town, State cemetery, crematory or other place)

R.T. Foard Funeral Home, 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rising Sun, MD 22. Name and Address of Facility R.T. Foard & Jones, Inc. 21. Signature Ineral Service Licens Main St., Newark, 122 W. DE 19711 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician ROBABLE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner rdion Sequentially list conditions, many, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-trans Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s has autopsy performed? Yes 2 certificate 2 XNo Yes 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No 24 hours after death Funeral Director; A Accident
Suicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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only one)

29b. Signature and title of certifier

State Registrar

Vinod Kripalu, M.D. 32. Registrar's Signature

06

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

314 East Main St.,

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

C10005

Newark, DE 19711

29d. Date signed (Month, Day, Year)

January 6, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0/ 2011 Ī Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mandrin Chesapeake Hospice House Harwood Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Months Director 0171271930 Virginia 226-30-7969 80 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Prince George's College Park 1

Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6100 Westchester Park Drive #1718 20740 United States 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Word Processing Manager Religious Service Org. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Coy E. Deel Cecil Kirby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ira Kalfus / Husband 6100 Westchester Park Dr. #1718, College Park, MD 20740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place Panorama Mem. Gardens 01/05/2011 Waterlick, Virginia 21. Signature ^{22. Name and Address of Facility}George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph sician/ disease or condition resulting in death) ULON Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated every limit in the cause of the cause Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Dav Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? neral Director; After this certificate has been si filled in by the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ANDRIA မ 1 Yes 2 No Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred disc 1 Natural 5 Pending work 1 🗌 Yes 2 No Accident Investigation 24 hours after deal Funeral Director; Suicide 6 🗌 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completed fi (Check | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 2 Signature and title of certifier 29c. License numbe aw address of person cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month

as

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event; It is "hwd call Examiner must be notified at anones.

1	OT VI(al HeCOrdS, P.O. BOX 6 Physician: The law requires that the death certif this certificate has been signed by the attending rail director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregnancy 1	
	OrdS, F equires that een signed I ould be det	þ	Part II. Other significant conditions co	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did to
3	(al HeC n; The law r ificate has b or, page 2 sh	e Completed	25. Was case referred to medical		24a. Was a autops perfori 1 □ Yes
3	Sicia sicia cert	m	examiner?	Hospital: 2 FR/Outpatient 2 FR	
	UNUSION OT VITAL HECONGS, To the Hospital or Attending Physician: The law requires t within 24 hours after cleath. To the Funeral Director: After this certificate has been signs completely filled in by the funeral director, page 2 should be	Certification: To	27. Manner of Death Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No	d. Describe ho f. Location (St City or Town
井口	o the Hospit ithin 24 hours o the Funera	Medical (29a. Certifier (Check only 2 Medical Examone) 29b. Signature and title of certifer	ysician: To the best of my knowledge, death occurred at the time, date and place, an inner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. 29c. License number	at the time, d
4	F > F 8		1 Ashus	(JM) D 57708	2
	RB 10+1 Sta Registr			mompleted cause of death (Item 23a) (Type, Print) M.D., CENNA MEDICAL CENTER, 7-C POST OFFICE 32. Redistrar's Signature 4. January	RP, WA
	DHMH 17 Rev 1/2	001		ORIGINAL	

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Frank Earl Kolstrom JANUARY 2011 4:35 PM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CIVISTA MEDICAL CENTER LA PLATA CHARLES If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months 215-52-9178 62 Dec. 30, 1948 Washington D.C. Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2 □ No Charles Indian Head 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29 Greenwood Place 20640 Completed by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces: 1 □Yes 2 □ No If Yes, Give Year or DatesVietnam 1 Never Married 2 Married 1 □Yes 2 □No Specify: 3 ☑ Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Engineering Technician U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Earl A. Kolstrom Mildred J. Herndon 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adam A. Kolstrom Brother 730 Monroe Bay Ave., Colonial Beach, Va. 22443 20b. Place of Disposition (Name of cemetery, crematory or other place) Jean. 13, 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Trinity Memorial Gardens Waldorf, Maryland 21. Signature of Funeral Service Licer 22. Name and Address of Facility Williams Funeral Home, P.A. M00668 4270 Hawthorne Rd., Indian Head, Md. 20640 23a. Part 1. Enter the of ease, or complications that cause shock, or heart follure. List only one cause or each the death. Do not enter the mode wdyln such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Onset and Death Squertially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as /Medical IF FEMALE 23d. Date of delivery Month Day Year bacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ın sy med? 2 No ence 6 ☐ Other (Specify) ow injury occurred treet and Number or Rural Route Number, n, State) cause(s) and manner as stated. late and place, and due to the cause(s) 9d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 24a per med cert G911 1728/11 dk
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

DORF, MD 20602

25

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

State

Registrar

ank

Mt. Airy, MD 21771

S. Main Street,

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1502

Thaker

Year.

Nilay

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JAN. 2011 JOSEPH CARL KELLY 1522 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 15 COVE LANE OCEAN PINES WORCESTER If Under 1 Year If Under 24 Hrs Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months MAY 16, 1 X M 2 □ F PENNSYLVANIA **Director** 75 145-26-1960 Î935 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits be notified at irectol 1 Yes 2 No MARYLAND WORCESTER OCEAN PINES Ö 10e. Street and Number 10f. Zip Code è 10g. Citizen of What Country? Funeral er than "natural", or items 23a the Medical Examiner must b 15 COVE LANE USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 XYes 2 No Black White etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 XNo Specify: WHITE If Yes. Give Specify: 3 Widowed 4 Divorced Completed Year or Dates. 1958-60 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) VICE PRESIDENT MANUFACTURING 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ MILDRED TOWEY EARL KELLY J. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau PATRICIA A. KELLY/WIFE 15 COVE LANE, OCEAN PINES, MARYLAND 21811 20a. Method of Disposition 20c. Location - City or Town, State JAN.8,2011 EASTON, PA Signature of Funeral Service Licensee 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975 Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each line. e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic Liver Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Destension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami law requires that the death certificate be executed ohysician and the burial-transit - Q U-Due to (or as a consequence of): resulting in death) Last physician Physician/Medical attending p 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an cate has l autopsy performed? Yes 2 No Physician: The certificate 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2X No 1 Tes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 1 Natural 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred or Attending After 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: At 2 Accident
3 Suicide
4 Homicide M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

State Registrar

Medical

29a. Certifier

only one 29b. Signature and title of certific

2 ∐ 3 □

31. Date filed (Month, Day, Year) **JAN 0 5 2011**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Convay, DO

Maryland 21215-0036

Baltimore.

Box 68760

P.O.

Records,

Division of Vital

DHMH 17 Rev 7/2009

10344 Old Oce an Coly

32. Registrar's Signature

1 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

29c. License number

Certificate of Death

2. Date of Death

23d. Date of delivery Month Dav 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐No AUTUMP ASSISTED

5,2011

3. Time of Death

 A^{M}

8:25

9. Birthplace (State or Foreign Country)

Maryland

14. Race - American Indian, Black, White, etc.

Specify: White

10d. Inside City Limits

1 ☐ Yes 2X No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

JAPUREY

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

D0019019

1.5.11

32. Pagistrar's Signature

- mit ms

31. Date filed (Month, Day, Year)

JAN 07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 340 Mill ST. HALKISTOWN Mb 21740 VASANT DATTA MD

State Registrar 1 - State Registra

1. Decedent's Name (First, Middle, Last)

DHMH 17 Rev 1/2001

3H- 7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Midgle, Last) 2. Date of Death 3. Time of Death OWENHAUP Physician/ FNRU 2011 9:20 PM JANUARY Medical and number 4a. Facility Name (if not institution, give street 4b, City, Town, or Location of Death **Examiner** 4c. County of Death Medica Cento, HAGESBWN Wastingen If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 070-18-7183 1 XM 2 □ F Hours Min. Months (Month, Day, Year) 14,1923 New York Director 87 May Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington County Hagerstown 1 X Yes 2 □ No 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 958 A St. Clair St. 21742 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 2 Yes 2 7 No If Yes, Give 1943 - Year or Dates. 1945 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status Race - American Indian, Black, White, etc. Examiner 5 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 X Widowed 4 ☐ Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d 2 should be filed within 72 lath and Mental Hygiene.
127 is marked other than "r traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Electrician Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Peter Lowenhaupt Emma Wattron Lowenhaupt permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Lowenhaupt-son 1022 St. Clair St. Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State 1-7-2011 Rocky Gap Veterans Flintstone, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern BLvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tallure. List only one cause on each line, Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to initialize cause. Enter Underlying Cause (Disease or impury that initiated events resulting in death). Leat Physician/Medical Examiner attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Descript at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Yes 2 🗌 No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Completed Unknown been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 Yes Be . Was case referred t medic examiner? 26. Place of Death (Check only one) examiner? Hospital မ 24 hours after death.

Funeral Director: After this letted filled in by the funeral dii Inpatient 2 ER/Outpatient 3 🗆 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident М Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State

Within 2

DHMH 17 Rev 7/2009

Registrar

only one)

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month DORA P. LERNER Medical 09 2011 ania 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Jospita, Baltimone Baltimone 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) GERMANY **Funeral** If Under 24 Hrs. 8. Date of Birth 1 □ M 2 🗓 F APR 8 192 Months Min Director 89 12 7273 045 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits notified 28a-f FL. BOCA RATON 1 Yes 2 No 10e. Street and Number ŏ 10f. Zip Code permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be I 10g. Citizen of What Country? Funeral 5301 NW 2ND AVE 33487 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces þ 1 Never Married 2 Married Black, White, etc. 1 ☐ Yes 2 😿 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 X Widowed 4 □ Divorced Specify: Year or Dates WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SECRETARY SYNAGOGUE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ALFRED PFINGST FRIEDA LOEWENSTEIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RICHARD LERNER 102 CYGNET CR FOREST. VA 24551 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Beth Israel Cemetery | Jan 14 2011 ROANOKE VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Oakey Inc. P.O. Box 1579 Roanoke, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Annroximate Interval Between Onset and Death Immediate Cause (Final Physician/ Healtheau elated. disease or condition resulting in death) Medical Examiner Due to (or as a consequence of) Sequentially list conditions, Examine if any, leading to immedia cause. Enter Underlying Cause (Disease or iinjury Due to (or as a nonsequence or): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as t attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) page 2 should be detached for in the past 12 months? Pregnant at time of death Month Dav 2 | No Year the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director. After this certificate to completed filled in by the funeral director management of the filter of the funeral director. performed? Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural (Month, Day, Year) 5 Pending Accident Investigation 1 Yes 2 No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DV NOUSE 020 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** ouise. A. LUDICKE - 40PM 515-January 2011 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Columbia Howard Lorien Nursing Home If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign 5. Social Security Number 3irthpia Country) MD **Funeral** 6/11/1932 Months Days Hours 1 □ M 2 🖸 F 78 219-28-8085 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notifled at 1 ☐ Yes 2 No Ellicott City Director MD Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2815 Willow Ln. 21043 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. e filed within 72 hours after dal Hygiene. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 201No Specify: White Specify 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Ticket Agent TWA Airline permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygic Important: If Item 27 is marked other i any Injury or other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Gerard Ludicke Anna Feiler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8817 Stonehouse Dr., Ellicott City, MD 21043 Jane Warfel / Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/10/2011 | Baltimore, MD New Cathedral Cem. 22. Name and Address of Facilitharry H. Witzke's Family FH, Inc. M01411 21. Signature of Puneral Service Licensee 4112 Old Columbia Pike, Ellicott City, MD 21043 (BU + Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a, Part1. Immediate Cause (Final disease or condition resulting in death) Physician ARDIO-PULMONARY Few minuto /Medical Due to (or as a consequence of): Examiner 170 CARDIAL Sequentially list conditions, if any, leading to infiltediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed TPERTENSION Due to (or as a consequence of): attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 ☐ Probably 4 ☐ Unknown HERNIA 1 Tyes HIATAL Be Completed Degenerative 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? STROKE 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manne of Death filled in by the funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, P.O. Box 68760, within 24 hours a To the Funeral L

> State Registrar

29b. Signature and title of certifier

N.B. VELLANKi

31. Date filed (Month, Day, Year) JAN 0 6 201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8850, COLYMBIA

32. Registrar's Signature

DHMH 17 Rev 1/2001

5

Barke

100

29c. License number

PARKWAY.

29d. Date signed (Month, Day, Year)

+ 308 Columbia, MP-2104

5/ January - 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Walter Litvinuck 2011 January 8:12 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Hospice of Queen Anne Centreville Queen Anne If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours 214-22-3548 Director 83 Feb 10. 1927 Marvland Usual Residence of Decedent death with the Maryland 10d. Inside City Limits show 10a. State 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No X Director Maryland Queen Anne Chester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21619 306 Bentons Pleasure Road Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc within 72 hours after 1 Yes 2 No WWII I 1 Never Married 3 Married Baltimore, Maryland 21215-0036 Specify: White 1 ∐Yes 2XX No þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Je filed wit.

*I Hygiene.

*I than "r Elementary/Secondary (0-12) College (1-4or 5+) s 1 and 2 should be filed wi f Health and Mental Hygier item 27 is marked other th Attorney General Practice 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John L. Litvinuck Sophia (unknown) ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21619 19a. Informant's Name/Relationship (Type. Print) Department of Health Important: If item 27 any injury or other tr Nancy A. Litvinuck, wife 306 Bentons Pleasure Rd. PO Box 650, Chester, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Cremation Jan 4, 2011 Chester, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility PO Box 160, Greensboro, 21. Signature of Fulfieral Service Licenses Freegle and Helfenbein Funeral Home, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final yeurs **Physician** Due to (or as a consequence of). artex disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or anying Cause (Disease or injury Due to (or as a consequence of): Examine requires that the death certificate be executed burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 I Unknown 9 Unknown þ signed by the period of the period of the details of the details of the details of the period of the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performed? 1 □ Yes 2 ► No certificate 2 □ No 1 ☐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Haypic 1 Tes 2 Mo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? After To the Hospital or Attending 1 Natural 5 Pending n 24 hours after death. e Funeral Director: Af letely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Medical Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) //and manner stated. (Check only one)

State Registrar

DHMH 17 Rev 1/2001

within 2

29b. Signature and

30. Name and address 132 I+U

31. Date filed (Month, Day, Year

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JAN 1 0 2011

ORIGINAL

105

of person who completed cause of death (Item 23a) (Type, Print)

uite

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

2011

12+

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Miller Harriett Lee Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner WMHS-RMC Cumberland Allegany 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8 Date of Birth **Funeral** 1 □ M 2 □ x Months Hours Sep 23 214-32-2876 Director 76 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Allegany Cumberland 1 □xYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14 Market Street Apt. 1 21502 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates. Specify: "natural" 3 Widowed 4 Divorced white the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) American Persian salesperson 12 should be filed wit lith and Mental Hygie 27 is marked other r traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mildred (Cosgrove) Wilson Donald Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14 Market Street Apt. 1 Cumberland ME William Swartz MD 21502 son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Scarpelli Funeral Home, P.A. 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of ŏ 1 Burial 2 Kemation 3 Removal from State Important: If any injury or once. 1/10/201 MD Cresaptown 4 Donation 5 Other (Specify) Signature of Funeral Service 22. Name and Address of Fecility Property PA 108 Virginia Avenue: Cumberland, MD 21502 Part 1 Enter the disease of complications that caused shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death 23a. Part 1 Immediate Cause (Final Physician/ new (u-ilnon disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any leading cause. Enter Underlying Examiner Due to for as a conse, uence of as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or liniury and that initiated events resulting in death) Last Due to (or as a consequence of): by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death been signed by the a should be detached Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has performed this certificate 2 🗌 No 1 Yes Yes 2 No To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1
Yes 2 1No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1-Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Januar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UMBERLAND. 924 IKRAMADITYA POONAI M.D. 31. Date filed (Month, Day, Year) State OS NAE Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M	larylar	•				d Mental H	lygien	e	
			Registrar 1. Decedent's Name (First, Middle, Las	n+1		Cer	tificate o	or Dea	<u>tri</u>	0.00	Reg. I	lo.	1.112277
	Physicia	ın/		•	11.150					2. Date of Month		Day Year	3. Time of Death
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	Examin	er	The Gardens @ Wi		i		East			atn	Ľ	Talbot	n
****	Funeral		5. Social Security Number 6. S	ex		last birthday)	If Under 1.)		Inder 24 H	rs. 8. Date of	Birth	Q Riv	hplace (State or Foreign
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	*		Usual Residence of Decedent	, ,					'_	1/2 34			
	/land f sho	호	10a. State 10b. County	10c. City, Town or Location Easton								10d. Inside City Limits	
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	th wit	Funeral	20 Papermill S			a Lia ii				(n) 16 16 1			
	r dea or ite		11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces?			Yes, specify (of Hispani Cuban, Me	xican, Pue	Specify Yes or Nerto Rican, etc.)	10-	14. Race - Ame Black, White	
38	al", o	d by	3 XWidowed 4 ☐ Divorced	1 ☐ Yes 2 X If Yes, Give Year or Dates.	No	1	☐ Yes 2 ☐	No Sp	ec <i>ify:</i>			Specify: W	nite
ŏ	hours natur ical I	Completed	15. Decedent's E	ducation			ent's Usual O				16b.	Kind of Business	Industry
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p	filed al Hy d oth) Be	17. Father's Name (First, Middle, Last)							ame (First, Midd			
χ	uld be Ment narke	T ₀	Walter F. Ru						PNII	a G. T	urne		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (T) William R. Med	rpe, Print) dford/So	n							or Town, State, Zip DE 1995	
Ġ,	and Heal tem		20a. Method of Disposition			Place of Dispos			!	Date		Location - City or	
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票	mit. F partm portal / injul		21. Signature of Funeral Service Licens	<u></u>		22.	Name and A	ddress of F	acility F	ramptom	Fun	eral Home	P.A.
m	a in De		Michael T.	Eskow		2	16 N. I	Main	st.,	Federal	sbur	g, MD 21	632
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yeard to .	Physician/		Immediate Cause (Final disease or condition	Colo		1 endo	metri	10	. ه محسن	o o m	etas	Fracis	Onset and Death
	Medical Examiner		resulting in death)										
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Division of Vital Records,	or Att	Certificate:	4 Homicide determined	28e. Place of Injubul	ury - At ho c. <i>(Specif</i> y	ome, farm, stre	et, factory, off	ice			(Street a	nd Number or Run e)	al Route Number,
5	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifying Phys	ician: To the best of	my knowl	ledge death o	courad at the	time date	and place	and due to the	cauco(c)	and manner as sta	ted
	e Hos 124 hr e Fun leted	Medical		ner: On the basis of e	xamination	n and/or investi	gation, in my o	pinion, dea	th occurre	d at the time, dat	e and plac	e, and due to the c	ause(s) and manner stated.
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 24a per hospice 6912 2/4/11 dk
State of Maryland / Department of Health and Mental Hygiene

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Well Study Month, Day, Year Office (Month, Day, Year) Office (0 4 ¥ 0		29b. Signature and title of certifier						1	1	
State 31. Date filed (Month, Day, Year) Of 2011 32. Registrar's Signature		10		1 1 Gall	7			50496	>	01/03	120	11
State 31. Date filed (Month, Day, Year) 14 2011 32. Registrar's Signature		+=		- 0 44 - 4 0 0	ompleted cause of death (Item 2	(3a) (Type, Prin) (1)	1+	class	o de lua	10	1211 11
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Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Carl H. Manke Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Western Maryland Regional Med Ctr. Cumberland Allegany Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 **X** M 2 □ F Days Min ^{ar)}1921 June 13, Wisconsin **Director** 390-12-9080 89 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at irector MD Allegany LaVale 1 Tes 2 X No 這 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 926 Center St. 21502-7323 U. S. A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces 1**x** Yes 2 □ No 1942 If Yes, Give "natural", or ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 X Widowed 4 Divorced Specify Completed Year or Dates 1945 White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Letter Carrier Postal Service permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Manke Frances Hoffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Manke Son 926 Center St., LaVale, MD 21502-7323 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State S NV Vet Mem Cem Jan 18, 2011 Boulder City, NV 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Hafer Funeral Service, P.A. 1302 National Hwy., LaVale, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ acute disease or condition resulting in death) ML day Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury g physician and stransit the burial-transit Exami death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death signed by the at d be detached for 1 Yes 2 L 9 Unknown 9 Unknown or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate 2 🗌 No 21 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 1 Tes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Inpatient 2 ER/Outpatient 3 DOA this 7. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗌 No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 | | 3 | | only one) 29b. Signature and title of ce tife 29d. Date signed (Month, Day, Year) 6,2011 JANJON 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vikramaditya Poonai, 924 Seton Dr., Cumberland, MD 21502 31. Date filed (Mooth, I 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

P.O.

Division of Vital

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Michael Allen Mu	•	Sir-For State			and / Depa	artment of	f Health an				ible.	0 1 1	21000
Physicia		Registrar 1. Decedent's Name (First, Midd	le.Last)		Cei	rtificate of	Death		2. Date	of Death	g. No. /		3. Time of Death
Medical Examir		Michael	A11						Mon Jan	uary 4,	Day 2011	Year	1923 hrs
a		4a. Facility Name (if not institution 245 Chanalee Road	on, give st	reet and nu	ımber)		4b. City, Town, or Rising Sun	Location of De	ath		4c. Cou Ceci	unty of Death	
Funeral		5. Social Security Number	6. Sex		7. Age (In yrs. I	ast birthday)	If Under 1 Yes			ate of Birth	(MM/DD/)	(YYY) 9. Bir	hplace (State or
Director		220-82-9891	1 X M	2F		49 Yrs	Months Day	s Hours I	Min. 01	/02/	1962	Co	n Elkton untry) Mary Land
aoy	ŀ	Usual Residence of Decedent 10a. State 10b. County		 	10c. City,	Town or Locat	ion		-			-	10d. Inside City Limits
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ith the Maryland 123a or 28a-f shov optified at ooce.	Direct	10e. Street and Number					10f. Zip Code	1.1			-	of What Cour	-
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death v	Funeral	1 Never Married 2 X	larried 1	Armed F Yes	orces?	If Y	es, specify Cuba	n, Mexican, Pue				White, etc.	
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21,5 hould b and Men is mar-	일	19a. Informant's Name/Relation				19b. Mailing	g Address (Stree	et and Number	or Rural Ro	oute Numb	per, City or	Town, State	, Zip Code) 1 9 1 1
and 2 sho cafth and 2 sho cafth and range irraumati		M. Rebecca Mur 20a. Method of Disposition	ray	/ Spo			inns Roa		Date	111, M		tion - City or	
Baltimore, permit. Pages 1 a Department of He Important: If ite	İ	1 Burial 2 Cremation		Removal fr	om State	crematory or ot			nuary			•	
altin mit. P partme ports or	1	4 Donation 5 Other S 21. Signature funeral Surrey	<i>pecify:</i> Licens				lame and Addres		2011 ouch	Fune	Newar ral H	ck, De Home	laware
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Physician /Medi_d		failure. List only one cause	on each	line.			- Contact						Between Onset and Death
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	<u>=</u>	Sequentially list conditions, if any leading to immediate	b	etaturas a	consequence o	0							
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executed an and al - transit		events resulting in death) Last	d.	·	,	,							
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876(tificate ng phy as the b		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	he	23c. If yes, 1 Live t	outcome of preg pirth		tal death 3	Ectopic pre	gnancy		23d. Da Mor	ate of deliver) Day Year
Box 68760 e death certificate b the attending physic	. <u> </u>	1 Yes 2 No 9 Ur	known	4 Pregr 9 Unkn	nant at time of de	ath = =	her (Specify)						
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og Phy	-	27. Manner of Death	1,1-2	28a Date		28b. Time of I	njury 28c. Inju	ıry at Work?	28d. D		ow injury o		
Vision or Attend after death. Director	Catio		ding estigation	Jan 4, 2	2011	FOUND: 1923 hrs		Yes 2 V No					
DIVISION Sepital or At hours after do oceral Direct y filled in by	Certification:		ld not be ermined		Other (spe		et, factory, office	bullaing, etc.	or	Town, Sta	ate)	sing Sun, M	ral Route Number, City
the Ho hin 24 } the Fu	Medical C	29a. Certifier 1 Certifying F	miner:Or	To the bearing the basis	st of my knowled of examination a	ge, death occu	rred at the time, d		and due to	the cause	(s) and ma	anner as stat	ed.
To wit	We.	29b. Signature and title of certif		id manner s	stated.		29c. Licen:	se number			29d. Date	signed (Mo	nth, Day, Year)
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12		 Name and address of perso Ana Rubio MD. As 		•			imore Street,	Baltimore	MD 212	23			
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11-00157 Irvin Leigh Matus Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Physicia	ın/	1. Decedent's Nam								2. Date of Month	Death			3. Time of Death
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Funeral Director		5. Social Security N	12	7. Age	(In yrs. la	st birthd	ay) If Un Mont	ths Day		Min	of Birth (N 25/1	1		nplace (State or New York
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Baltimore, pernit. Pages I an Department of Hee Important: If itee	Ш	1 Burial 2		Removal from State	'	-	or other place Cremat			1/11/201	1 3	Baltimo	re.	MD
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Physician /Medical Examiner	ľ	failure. List online Immediate Cause (I or condition resulting	ly one cause on ea Final disease a.	nications that caused the ach line. Hypertens Due to (or as a consequence)	ive	Athe								Approximate Interval Between Onset and Death
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month AN 20 i VII Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis 6. Sex 1 M 2 Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min. Days 972271934 Washington. 578-42-7423 76 Director DC Usual Residence of Decedent or 28a-f show 10a, State 10b. County death with the Maryland be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Edgewater Marvland Anne Arundel 10f. Zip Code 10g. Citizen of What Country? Funeral 23a **Examiner must** 312 Londontown Rd. 21037 USA items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces 1 Yes 2 No Black, White, etc. "natural", or þ 1 Never Married 2 X Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Specify. White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mential Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John Henry Rodgers Sarah Tarman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia M. Rich/ Daughter 219 S. Vance Drive, Beckley, WV 25801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Kalas Crematory 1/4/11 Edgewater, MD 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Anset and Prath Physician/ MASTATIC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Due to for as a partieutierne of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burla-transit completed filled in by the funeral director, page 2 should be detached for use as the burla-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Month Day Year 1 Yes 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig page 2 should b Completed 1 Yes 2 No 3 Probably 4- Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗆 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work? Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title A d. Date signed (Month, Day, Year) 03 2011 who con pleted cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year JAMES FRANKLIN MATTHEWS January 24 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick 5. Social Security Number If Under 1 Year I ff Under 24 Hrs. 6. Sex 8. Date of Birth 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ፟፟፟፟ M 2 □ F Months SEP 6 1941 218-38-1264 69 Frederick, MD Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Brunswick Frederick MD 1X Yes 2 ☐ No 10e. Street and Numbe 10f. Zip Code 10g Citizen of What Country? Funeral 21716 USA 524 West Potomac Street 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married 2 X Married 9 Baltimore, Maryland 21215-0036 1 Yes 2 No White "natural", 3 Widowed 4 Divorced Completed Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Al Hygiene. East Alcoa Elementary/Seconday (0-12) College (1-4 or 5+) 1 and 2 should be filed with f Health and Mental Hygien item 27 is marked other th Caster Buckeystown, MD 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Evelyn Hoffman James A. Matthews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 21716 524 West Potomac Street, Brunswick, MD Josephine Matthews, Wife item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 and Department of I Important: If ite any injury or of ■ Burial 2 □ Cremation 3 □ Removal from State St. Paul's Episcopal 1/8/11 Point of Rocks, MD 4 Denation 5 Other (Specify) 21. Signayre of toneral Service Scensor 22. Name and Address of Facility
John T. Williams Funeral Home
100 Petersville Road, Brunswick, MD Williams, Owner 21716 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Physician/ disease or condition ans Medical resulting in death) Due to (or as a consequence o Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a conseque Examin sician and burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Medical death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 🗌 No ed by the a detached f 9 Unknown 9 I IInknown o Other significant conditions contributing to death but of resulting in the underlying cause given in Part I. signed b Part II 23e. Did tobacco use contribute to the cause of death? ď þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy Hospital or Attending Physician: The certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner? **Division of Vital** funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending injury work? n 24 hours after death.

e Funeral Director: After the function of the functin Accident Investigation 2 🗌 No 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the I 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie and addres who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JAN

r's Signature

32. Regist

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ 2011 6:00a January Roy W. Meyer Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 21702 8143 Clayborne Drive Frederick Social Security Number 6. Sex 1 A M 2 A F 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours April 25,1922 Illinois 89 356-03-0475 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature" any injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Frederick Maryland Frederick 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 8143 Clayborne Drive 21702 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. If Yes Give Specify: White Year or Dates. WWII Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Electronic Technician Electronics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Myrtle Wood Paul W. Meyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Springhill Drive, Frederick, Maryland 21702 Ronald E. Meyer/ Son 6645 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 1/7/2011 4 □ Donation, 5 ☒ Other (Specify) Entombment Mt. Olivet Cemetery Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Homes 1621 Opossumtown Pike, Signature of P. A. Frederick, Maryland 21702 Part 1. Enter the disease, or complications in a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line. Onset and Death Immediate Cause (Final Physician/ DEMENTIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last to (or as a consequence of) attending physician a for use as the burial-Physician/Medical ¿ Bladder Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No by the a Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown has been sign 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page perform certificate 2 No Yes 2 No Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 🕻 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 M Residence 6 ☐ Other (Specify) Director; After this it in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accider 5 Pending work 1 Yes 2 No Accident Investigation ☐ Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check Certifying Nurse Fractioner To the best of my knowledge, do d at the time, date and place, and due to the e 29b. Signature,and title of certifi 29d. Date signed (Month, Day, Year,

State Registrar Linda C.

31. Date filed (Month, Day, Year)

Muehl,

JAN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C.R.N.P.

32. Regist ar's Signature

M.S.

K069310

UD

1564 Opossumtown Pike, Frederick, Maryland 21702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nicholson Marie Karen 2011 8:20 A January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Cumberland Western MD Regional Medical Center . Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 💢 Months Days Hours Min Country) 44 194-50-2502 **Director** 02/05/1966 Pennsylvania Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director Cumberland MD Allegany 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21502 Funeral 109 Arch Street death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. should be filed within 72 hours after donated and Mental Hygiene.

is marked other than "natural", or i þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Completed 3 Widowed 4 X Divorced White other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gladys Hillegass Greenawalt E. Leona Eugene 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 129 Windwood Circle, Bedford, PA 1 and 2 s of Health a item 27 Leona G. Hillegass / Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/10/2011 Cumberland Crematory Cumberland, MD 21. Signature of Funeral Service 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ ulmory disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immedicause. Enter Underlying Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury orolee and-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown the Division of Vital Records, P.O. been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed within 24 hours after death.

To the Funeral Director; After this certificate I completed filled in by the funeral director, pagr 1 ☐ Yes 2 ☐ No Yes 2 XN 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 Minpatient 2 ER/Outpatient 3 DOA ၉ 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 10066101

Registrar

DHMH 17 Rev 7/2009

State

willow brook Rd Cumberland MO 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4 12500 will 32. Registrar's gignature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - State Amend 29d per phys., DOR, Registrar 1/7/11, LDR Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 03Day Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death i a Sbur Or age Nursing + Rehab Center (icomico . Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 😿 F Month, Day, Min Director 28a-f shov 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 ✓ Yes 2 ☐ No Sbur COMICO 10e. Street and Number 10f. Zip Cod 10g. Citizen of What Country? Funeral U 5 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or ury or other traumatic event, the Medical Exami Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. If Yes, Give Year or Dates Completed 3 Divorced 4 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) + teacher County Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Su မ Waro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other trong once. Devenia llace 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Cambridg 4 Donation 5 Other (Specify) 10 21. Signature of Funeral Service Licensee 22, Name and Address Facility Funeral Home, lle Shington 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASCVD Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Grive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No 4 Pregnant 9 Unknown Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Director: After this certificate 2 No 1 🗌 Yes Yes To the Hospital or Attending Physician: within 24 hours after death. completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 🗌 Yes 2 No Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 DQA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 Tyes 2 🗌 No Accident Suicide Investigation Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 03/11 29b. Signature and tip of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Babulal Dro. 106 Ru tord 57 048 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 2 2011 2011 Walter Thomas Powers 12:45 RM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6412 Tilden Lane Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours Sept. 9, 1918 1 M 2 F Months 218-56-7513 92 Yrs Vancouver, Canada Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2 No Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6412 Tilden Lane 20852 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify "natural", Specify Completed 3 Divorced 4 Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) the Accountant Financia1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental F ပ Thomas J. Powers Ella Preston Powers other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or any Patrick W. Powers/ Son 4728 Mussetter Road, Ijamsville, MD 21754 20b. Place of Disposition (Name of cemetery crematory or other place)

Metropolitan

Crematorium Inc. 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Toremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jan. 3, 2011 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22 Molesworth Williams, P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Years Immediate Cause (Final Physician/ Coronary Artery Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami -transit that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Year Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Records, P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Arrhythmias 1 Yes 2 No 3 Probably 4 Tunknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has page certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 2 No 1 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Natural 24 hours after death. e Funeral Director: Aff Investigation Accident 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 🚇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of of 29d. Date signed (Month. Dav. Year) D0031239 Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville MD SOW, Edmonster Brue # 202 ranged Oute 31. Date filed (Month, Day, Year) 32. Regist ar's Signature State JAN Eneua Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Thomas W. Parton January 2011 8:10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 1**X** M 2 □ F Days Hours Min. (Month, Day, Year) 09-11-1950 Director 215 56 2934 60 Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 72 hours after death with the Maryland event, the Medical Examiner must be notified at Director 28a-f 1 ☐ Yes 2X No Linthicum Heights MD Anne Arundel 23a or 2 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21090 803 Lynvue Avenue United States or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: "natural" 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important. If item 27 is marked other this any injury or other traumatic event. The Salesman Industrial Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William D. Parton, Sr. Vera D. Caldwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Foggy Bottom Drive Sykesville, MD 21784 William D. Parton, Jr./brother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State Ardent Cremation Svc. 1-6-2011 Hanover, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, to (or as a some equence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and I-transit law requires that the death certificate be executed Exam a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No the g Unknown P.0. cate has been signed by a page 2 should be detach th but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to de 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director. After this certificate has autops\ death? 2 14 No or Attending Physician: The 1 Yes 1 🗌 Yes Division of Vital 25. Was case referred to examiner? funeral director, 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 Inpatient ည ER/Outpatient 3 DOA 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accider
3 Suicide Accident Investigation filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 0 ress of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

10215

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Peters Day Allen Larry P M January 2011 7:33 Medical 4a, Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Devlin Manor Health Care Center Cumberland Allegany Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Min. 1 🔀 M 2 🗆 F 220-40-1159 66 Director 10/26/1944 Maryland Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director MD Allegany Cumberland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 USA 759 Maryland Avenue 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black White etc. or 1 Never Married 2 Married þ 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Hygiene. 3 Widowed 4 X Divorced Completed White Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing 10 Laborer is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Proudfoot Mae ပ Peters Floyd Lovell Dorothy 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13609 Fir Tree Lane, Cresaptown, MD 21502 James Peters / Brother permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Cumberland Crematory 01/04/2011 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 23a. Part 1. Filer the diseas, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

3 months Immediate Cause (Final Physician/ Metabolic disease or condition Medical Examiner resulting in death) Sequentially list conditions, Examine if any, leading to Immediate cause. Enter Underlying Sue to for as a consequence of attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Physician; The law requires that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 2 No ed by the a detached f Unknown 9 Unknown signed by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Z Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page certificate Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Hospital 1 ☐ Yes 2 🔀 No Other: ည 1 Inpatient 2 ER/Outpatient 3 IDOA this 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director. At completed filled in by the fu Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f, Location (Street and Number or Rural Route Number, determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in rily opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Box 68760 P.O. Records, Division of Vital Hospital or Attending

State Registrar DHMH 17 Rev 7/2009 29b. Signature and title of certifier

31. Date filed (Month, Day, Year) Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Qamar U. Zaman, M.D.,

29c. License number

D0023371

12502 Willowbrook Rd, Suite 440, Cumberland, MD

29d. Date signed (Month, Day, Year)

January 3, 2011

21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ e an ette 6:10pm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Julia Manor Washington ealth MRP Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 9/9/1931 1 - M 2 - T 79 England Director 578-86-1101 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director MD Washington Hagerstown ¹X☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21740 USA 402 South Mulberry Street 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ģ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) 12th College (1-4 or 5+) Housewife Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Pryor Ada Murrel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) South Mulberry St. Hagerstown, MD211740 Steven Pfeiffer/son Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) July or Town, State 1 Burial 2 Cremation 3 Removal from State 1/8/2011 Waldorf, MD Donation 5 Other (Specify) Trinity Mem.Garden . Signature of Funeral Service Licenses 22. Name and Address of Facility Briscoe-Tonic Funeral Home 94 Old Washington Rd Waldorf, MD20601 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and been signed by the attending physician and should be detached for use as the burial-transit Hypertension that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by emention 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 💢 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Accident 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Frint) Barbara Naden-Bluc 333MillStreet RNP 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 10 Registrar

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		State of Maryland / Dep	partment of Health and leartificate of Death	, ,		
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Fune	ral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		8. Date of Birth	9. Birthp	lace (State or Foreign
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or 28 e not	عُ	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Coun	try?
with with s 23a ust b	Finaral Director	2628 Quiet Water Cove	21401		USA	
leath Items er m	يًا ا	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Americ	
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Depa Depa Impo any ii	ouce.	21. Signature of Funeral Service Licensee	2. Name and Address of Facility Hardesty Funeral H	lome P.A.	12 Ridgely Annapolis,	Aye MD 21401
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To the Hospital or Attending Physician: The lawithin 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page	Medical	29a. Certifier (Check (Check only one) Certifying Physician: To the best of my knowledge, death basis of examination and/or inve	stigation, in my opinion, death occurred a	at the time, date and pla	lace, and due to the cau	se(s) and manner stated.
To the To the Comp	2	29b. Signature and title of certifier	29c. License number		Date signed (Month, D	
			D57028	V	m. 3. 8	2011
		30. Name and address of person who completed cause of death (Item 23a) (Type,			1.	
1454		Aditya Chopra MD 600 Ridg	cly the Ste 231	Annape	olis mD	21401
S Regis	State	31. Date files Month, Day, Year) 32. Registrar's Signature	1.41	,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 5, 2011 2:30 a M Shirley A. Rice Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Calvert Calvert County Nursing Center Prince Frederick If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** MĎ January 11, 1924 Director 86 <u> 212-42-0187</u> Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Prince Frederick MD Calvert 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral 20678 1602 Mason Court Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: "natural", Completed 3 Widowed 4 Divorced Black th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Someone Else's Home **Domestic** Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Ella Johnson Jack Hurley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Mackall - neice P.O. Box 451, Prince Frederick, MD 20678 of Health item 27 or other 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition emetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. **Holland Cemetery** January 8, 2011 | Huntingtown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sewell Funeral Home, P.A. Blady 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final thenoscienthe Physician/ Careliovascular d disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Physician/Medical Examiner Directo for as a consequence of: and -transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death ed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be det Completed by 1 Yes 2 No 3 Probably 4 Unknown dementic Advonce 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Corotid autopsy death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Hospital Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State Medical 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29c, License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1-6.2011 D 50653 yan.c urana 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GYAN C. SURBWH Churchton Reale Deale 31. Date filed (Month, Day, Year) 32. Registra State .14 N Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Theda May Ross 2011 January 2150 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Calvert Memorial Hospital Prince Frederick Calvert 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2🛣 F Days Months Hours (Month, Day, Yea West Virginia **Director** 215-70-8945 77 January Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1980 Hummingbird Road 20657 USA hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1X Never Married 2 ☐ Married ģ Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: If Yes, Give Year or Dates White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 72 Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Assistant Handicap Facility Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Ross, Jr. Thelma Cassell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Roger Springer/Nephew 13465 Holly Spring Drive, Waldorf, MD 20601 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State any injury or Queen of Peace 1/10/2011 4 Donation 5 Other (Specify) Mechanicsville, MD Signature of Funeral Service Lipenses 22 AREHART ECHOLS FUNERAL HOME, P.A. ₩01458 Mary's Ave. La Plat 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Duc to (or as a consequence of, sician and bunal-transit Exami Due to (or as a consequence of): physician s the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a d be detached f 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by cate has been sig page 2 should b Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? certificate 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: မ 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury 1 Natural 5 Pending s after death. 1 Yes 2 No Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined building, etc. (Specify) 24 hours a Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 [within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title no 30. Name and add RBQ latin 31. Date filed (Month, De State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month William H. Richards Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Coustal Social Security Numbe 9. Birthplace (State or Foreign Country) Maryland 7. Age (In vrs. last birthday If Under 1 Year 8. Date of Birth **Funeral** If Under 24 Hrs. Days 1 XM 2 □ F Year. 220-26-3841 79 Director 24. 1931 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Federalsburg Caroline MD 1 Yes 2 K No Richards, William 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? Funeral "natural", or items 23a 406 Old Denton Road 21632 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatio. Elementary/Seconday (0-12) College (1-4 or 5+) Electrician E.I. DuPont 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Amanda Elizabeth Darling Harry L. Richards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 406 Old Denton Rd., Federalsburg, MD 21632 Doris A. Richards, Spouse 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 XX Cremation 3 Removal from State Bloomery Cemetery 01/06/11 Federalsburg, 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home akow Michael 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition

344 / V Calcar Carcinoma. Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause injury Due to (or as a consequence of) Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and abe detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 Yes 2 🔀 No Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tyes 2 🔀 No Other: 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗷 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be after deatl Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical 1 Z Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 01-02-2011 29505 0. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREGORIO M, BELLOSO; 5302 CHINABERRY DR. GALISBURY, MD 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

AS A

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 9 Physician/ Month January FRANCES RAMSBURG 2011 4:53 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Frederick Memorial Hospital Frederick Frederick Social Security Number 8. Date of Birth (Month, Day Year) Sept. 27, 1 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days 1 ☐ M 2 🔯 F Hours 86 Yrs. Mary I and 209-12-1721 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director West Virginia 1 ☐ Yes 2 X No Jefferson Harpers Ferry 10e. Street and Number 10g. Citizen of What Country? 25425 356 Morning Calm Lane United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc 1 Never Married 2 X Married Completed by 1 X Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates. WWII permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medicall 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Frederick College (1-4 or 5+) Administrator County Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Bertha Jones Merhl Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 356 Morning Calm Ln., Harpers Ferry, WV 25425 Herbert E. Ramsburg, Sr/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Jan. 12 2011 Rest haven or other place) 1 X Burial 2 Cremation 3 Removal from State 12, 4 Donation 5 Other (Spegify) Memorial Gardens Frederick, Maryland 21. Signature of Funeral Service Licensee Resthaven Funeral Services, 9501 Catoctin Mountain Hwy. Skkot Cody Frederick, P.A. MD 21701 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or point failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ HEART FAILURE CONGESTIVE Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): nding physician a use as the burial-t Physician/Medical 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ COPD. AORTIL STENOSIS. PERICARDIAL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed EFFUSION. NEW ONSET 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica To Be 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manney of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Mil M.D. 065126 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FREDERICK MEM. HOSP. 5.41UA 400 W. SEVENTH ST. Frederick, MD 21701 MAHPARA 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State

Registrar

Box 68760

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ <u>0</u>9^{ay} Month 01 $\underline{201}^{\text{Year}}$ John Nelson Ramsburg Sr. 9:50A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death
Frederick 1058 Arnoldstown Rd. Jefferson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 XM 2 - F 217-16-2361 88 Hours MD MD **Director** Usual Residence of Decedent 28a-f shov and 2 should be filed within 72 hours after death with the Manyland F Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f shoother traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Frederick Jefferson 1 🗆 Yes 2 🄀 No 10e. Street and Number 10g. Citizen of What Country? Funeral 1058 Arnoldstown Rd. 21755 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Yes 2 🔀 No If Yes, Give Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: Completed 3 Widowed 4 Divorced Specify: Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 6 welder steel CO Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Maynard Ramsburg Gertrude Baugher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Sines (Daughter) 1058 Arnoldstown Rd., Jefferson, MD 21755 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 Removal from State Union Cemetery 1/13/2011Burkittsville, MD 4 Donation 5 Other (Specify) Donard ddg B. Frittompson Funeral Home POB 18, Middletown, MD 21769 W . Part 1. Bhter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Snset and Death Physician/ Obstruction Chroni disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Replace ment Completed 1

Yes 2 □ No 3 □ Probably 4 □ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? .24 hours after death.

e Funeral Director: After this certificate has bleted filled in by the funeral director, page 2: autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ျှ 1 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

K. 0-1614

JAN

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

only one)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

varke

22037

Brunswick

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 9:48 Muriel Alexandra Ryan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death -castal lisbur lospice at the icomico Age (In yrs. last birthday)
55 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8 Date of Birth **Funeral** 1 M 2 X F Months Hours Min 121-50-7775 New York Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County with the Maryland 10d. Inside City Limits Director Maryland Crisfield 1 🗆 Yes 2 ื No Somerset 10e. Street and Number 10g. Citizen of What Country? USA 10f, Zip Code Funeral permit. Page 1 and 2 should be filed within 72 hours after death with. D. partment of Health and Mental Hygiene.
Important if flea 27 is marked other there" any injury or other traumati-21817 3417 Lawsonia Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 K Married Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Specify: white Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) picture framer fine art Be 18. Mother's Name (First, Middle, Maiden Surname) Anna Nicholaievna Dobrian 17. Father's Name (First, Middle, Last) ည Alexander Ivanovich Bogush 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3417 Lawsonia Rd., Crisfield, MD 21817 Jerome F. Ryan/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of competey, are matrix or other place)
Holy Trinity Russian Orthodox
Monastery 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 1/10/2011 4 ☐ Donation 5 ☐ Other (Specify) Jordanville, NY Signature of Funeral Service Licensee 2HOTTOWAY FUNETAL Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 domosa 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CARCINOMA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. E. iter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transil that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year ate has been signed by the page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autops 1 Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: ပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) HOSDICR 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury injury Natural 5 Pending after death. 2 🗆 No Accident 1 Tes Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one ind title of certifier 29b. Signature 29c. License number 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar's Signatu State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Carolyn Vivian Robinson 03, 2011 January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Baltimore-Washington Medical Center Glen Burnie 5. Social Security Number If Under 1 Year If Under 24 Hrs, 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8 Date of Birth **Funeral** 1 M 2 T Month: Hours Plainfield, N.J 77 11/26/1933 Director 577-46-6135 Usual Residence of Decedent 28a-f shov 10a. State 10h County 10c. City, Town or Location "natural", or items 23a or 28a-f sho 10d. Inside City Limits Director Md. Anne Arundel Odenton 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1012 Samantha Lane 21113 U.S.A. death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married ð Baltimore, Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 → No Specify: Specify: Black 3 Widowed 4 X Divorced Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 2 vears <u> Social Worker/Child Support Div. Md. State Government</u> is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file ည Richard Holmes Rebecca Dickerson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Gwendolyn J. Thompson/Daughter 1012 Samantha Lane, Odenton, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Nat'l. Mem. Park 01/08/11 Laurel, Maryland 22. Name and Address of Facility Henry S. Washington & Sons Co, Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 21. Signature of Funeral Service Licenses ausi 164 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Welmon Medical Due to (or as a onsequence of) Examiner 2045 Pensive Sequentially list conditions if any, leading to immediate Due to as a consequence of Exami that the death certificate be executed burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 ig phys anding p IF FEMALE: ses 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy atter for u in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death 5 Other (specify) signed by the a d be detached f q 🖂 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, law requires 2 No 3 Probably 4 Unknown 1 Yes been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an sate has bage 2 s autopsy perform Hospital or Attending Physician; The certificate | 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital: 2 1 ☐ Inpatient 2X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate; 28c. Injury at 28d. Describe how injury occurred Natural Natural 5 Pending injury 1 🗌 Yes 2 🗆 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D2752 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9500 ANNAPOLLS RUA I LAN K. Leach, M.D. LANHAM 20706 31. Date filed (Month, Day, Year)

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3:43AM Ruth Jefferson Reinhardt MUSICA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Examiner Prince George's Doctors Community Hospital Lanham Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🕱 F Months Days Hours (Month, Day, Year) 24 Rocksbury, VA 86 **Director** 225-20-6287 Usual Residence of Decedent 10a. State 10c. City, Town or Location with the Maryland ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Director MD Prince George's Cheverly Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20785 USA 5805 Dewey Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc ò 1 Never Married 2 Married Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2K No Specify: Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry
Prince George's County (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Board of Education Food Service Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve Delores Whitehead John Thomas Jefferson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosemarie Reinhardt-Drish-Daughter 4716 Hummingbird Dr., Waldorf, MD 20603 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🙀 Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 1/10/2011 Brentwood, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 4739 Raltimore Ave 22. Name and Address of Facility Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) max Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregrant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The raw within 24 hours after death.

To the Funeral Director: After this certificate has I autopsy performe 2 🗌 No Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: ၉ 1 Yes 2 1 No 🖊 Inpatient 2 🗌 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Yes 2 Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical The Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifies (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 01-05-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5632 ANNAPOLIS VICKEN 00 CH11K1 Date filed (Month, Day, Year State 2011

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 🤈 🕦 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ [™]01[™]/03/2**01**1 ам 7:00 Elizabeth W. Shumate Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Calvert Memorial Hospital/4th Floor Prince Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Social Security Number Funeral 1 🗆 M 2 🕱 F Months Hours 1470571928 DC Director 579-34-6217 Jsual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State Director 1 Tyes 2 X No MD Calvert Dunkirk 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral United States 20754 3101 Ashwood Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, or i Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No if Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: "natural", Completed 3 X Widowed 4 Divorced White traumatic event, the Medical 16a. Decedent's Usual Occupation Decedent's Education 16b, Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Flementary/Seconday (0-12) College (1-4 or 5+) LPN Nursing Home marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental F. 7 is mark ည Julia K. Toila Lewis E. Williams permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ashwood Drive, Dunkirk, MD 20754 Barbara Hutchison/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/08/2011 Cedar Hill Cemetery Suitland, MD 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Signaturo o Funeral Service Licenses Vary-Goff 8125 Southern Maryland Blvd., Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final OF Priysician/ disease or condition resulting in death) RUGRASSIVE COAPLICATIONS -24 FARI Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exam that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical certificate be Box 68760 as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy lo in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death 5 Other (specify) page 2 should be detached the Unknown 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I þ OBSTRUCTIVE PULMO-ANY DISFASE Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed 24 hours after death. Funeral Director: After this certificate 2 🗌 No Yes 2 1 Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 \(\simeg\) Yes Hospital Other: 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Litursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation completed filled in by the Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a Certifier 🕒 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in the opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29c. License number 144 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LRW 10 REDERICL 16IGE 7 32. Registrar Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

11-00063 Alfred B. Stanley, Sr. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

лтеа в	. Stanle	-	1- For State Registrar	State of MaryR		ertificate o		na ivien		Re	g. No.	1 1133	
	Physici I Exam		1. Decedent's Name (First, Name Alfred	_{liddle,Last)} Bernard S	tanley	, Sr.				Date of Death Month January 2,	Day Year	3. Time of Death 0920 hrs	
			4a. Facility Name (if not insti Peninsula Regiona		umber)		4b. City, Town, Salisbury	or Location o			4c. County of De Wicomico	eath	
	uneral irector		5. Social Security Number 218-50-131	9 6. Sex	7. Age (In yrs.	last birthday)	Months Da					Birthplace (State or reign Country) MD	
	any		Usual Residence of Deceder 10a. State 10b. Cou		10c. City	, Town or Locat						10d. Inside City Limits	
]	¥ .	tor		rchester		I	Hurloc				1 Yes		
į	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene. Importment of Health 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 6925 Hyns	on Road			10f. Zip Code	2164	13	10	g. Citizen of What C United	•	
4		by Funeral	11. Marital Status 1 Never Married 2 3 Widowed 4		If Y	as Decedent of I	an, Mexican, lo <i>specify:</i>	, Puerto Ri	can, etc.)	White, etc	Black White		
036			15. Decedent's Education (Elementary/Secondary (0-	12) College (1		during m	nt's Usual Occup lost of working I Cab Ow	fe. DO NOT			16b. Kind of Busine		
21215-0036		Be Co	17. Father's Name (First, Mic Charlie M	onroe Sta	nley,			Cece	elia	Thomp			
MD 2	2 Should h and M 27 is m imatic	To	19a. Informant's Name/Relat				Hynson				per, City or Town, St D 21643	ate, Zip Code)	
Baltimore, I	rages I and nent of Healt ant: If item or other tra		20a. Method of Disposition 1			Place of Dispos crematory or ot aith Cor	her place)				20c. Location - City East New	or Town, State Mkt., MD	
Balti	Departn Import injury		21. Signature of Funeral Sen	vice Licensee		2	16 N. Ma	ain St	., F∈	derals	uneral Ho burg, MD	me, P.A. 21632	
IN	ysician Legical		23a. Part I. Enter the disease failure. List only one ca	use on each line.			he mode of dyin	g, such as ca	ardiac or re	espiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death	
Exa	aminer		Immediate Cause (Final dise or condition resulting in deat		consequence								
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ca (Lisease or injury that initiate	use c.	consequence o								
76	outed ind transit	I Exa	events resulting in death) La	dd.	consequence o	or).							
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30x 6876	To the mopping of Accounting Frystein. The taw requires that the centure of executed within 24 hours after clearh. To the Fuoreral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	- 21	IF FEMALE: 23b. Was decedent pregnant past 12 months? 1 Yes 2 No 9	1 Live b	ant at time of de	2 Fe	tal death 3 her (Specify)	Ectopic	pregnanc	,	23d. Date of deliv Month	ery Day Year	
P.O. E	signed by th	ģ	Part II. Other significant co	nditions contributing to	death but not r	resulting in the u	inderlying cause	given in Par	rt I.			to the cause of death?	
Records	cate has been a	Completed								24a. Was ar autops perform 1 Yes 2	y prior t ned? death		
/ital	his certificate director, page	å	25. Was case referred to me examiner?	Hospital: 1	npatient 2	ER/Outpatient	policing	Ce of Death (· · · · · · · · · · · · · · · · · · ·	tesidence 6 Ot	ner:	
on of V	ath. or: After the funeral d	cation: To		28a. Date Dec 31,		28b. Time of le 2328 hrs	njury 28c. In	jury at Work?	? 28		ow injury occurred		
Divisi	within 24 hours after death To the Fuoeral Director: completely filled in by the	Certifica	3 Suicide 6 (4 ✓ Homicide	iould not be	e of Injury - At h doorway o	ome, farm, stree	et, factory, office	building, etc		or Town, Sta		Rural Route Number, City rel, DE	
the Ho	hin 24 h the Fuc npletely	Medical		Physician : To the bes Examiner:On the basis	of examination a								
ٔ ا	To Cor	Mec	29b. Signature and title of ce	and manner s	tated.			onse number			29d. Date signed (A		
			30. Name and address of per Donna M. Vincenti,		se of death (Item		W. Baltimor	re Street	Baltimo	re MD 212	23		
	St	ate	31. Date filed (Month, Day, Ye	ar) 32. Ré	gistrar's Signatu		W. Ballino	J 511001, 1		. 5, 1/15 2 12			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Haywood Earl Sharpe January 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Washington Adventist Hospital T<u>akoma</u> Park 5. Social Security Number Birthplace (State or Foreign Country) NC 8. Date of Birth (Month, Day, Yea Nov. 6, 19 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 🛛 M 2 🗆 F Days Hours Min. 246 64 2409 Director 64 Yrs. 1946 Usual Residence of Decedent shov 2 should be filed within 72 hours after death with the Maryland the and Mental Hygiene.
27 is marked other than "natural", or items 23a or 28a-f short raumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director DC 1 X Yes 2 ☐ No Washington 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2912 Nelson Place SE 20019 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 Specify:Black 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) District Government Supervisor 4+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Sharpe Flora Raspberry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health an Important: If item 27 is any injury or other trau Brian K. Sharpe/ 10526 Joyceton Dr. Upper Marlboro, MD 20774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 M Burial 2 Cremation 3 Removal from State Heritage Cemetery 01/15/2011 Waldorf, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Briscoe-Tonic Funeral Home Signature of Funeral Service Licens 2294 Old Washington Rd.Waldorf,MD 20601 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transi KIDNEY that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 2 K No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🖄 No Other: ျ 1 🔲 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: s after death. 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a

To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NBS NEZ-PARKNAY GREGNBELT 25A

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 54 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ Katharine Follin Sulzer January 5:30 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Berlin Nursing & Rehab. Center Berlin Worcester If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) Funeral 008-14-5478 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F 89 4 /13 /2 1 ear) Pennsylvania Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ems 23a or 28a-f sh r must be notified a 1 Tes 2X No Maryland Worcester Snow Hill 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6068 Basket Switch Rd 21863 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinonce. δ 1 Never Married 2 Married 1 ☐ Yes 2 🔯 No If Yes, Give atherine F Sulzer Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaking Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ James Follin Maude Burnham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jim F. Sulzer Back Street Nantucket, Mass. 02554 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1
Burial 2
Cremation 3
Removal from State 4 ☐ Donation 5 ☐ Other (Specify) First State Crem. 1/7/11 Millsboro, DE 108 William St. 21. Signature 22. Name and Address of Facility Service Licens The Burbage Buneral Home Berlin, MD 21811 23a. Part 1. Ent. In disea of or complications that of used shock, or hear failure. List only one cause of each line. used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Cerebrovascular accident / Medical Due to (or as a consequence of): Examiner Ventricular Arrythmia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of). ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗶 No Month Dav Year 1 Yes 2 2 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗶 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 🗆 No Yes 2 X No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 XNo Other: ည 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 X Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending after death.

Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Makse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signa d title of certifie 29c. License number R 135131 January 6, 2011

State Registrar 9715 Healthway Dr, Berlin,

MD

21811

address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

32. Registrar's Signature

Pennie Savage,

Day

31. Date filed (Month,

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 7, 2011 Year 1:10 p. м Steinheimer John Joseph Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** c. County of Death **Frederick** 6678 Meadowside Drive Frederick 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign 1 🏝 M 2 🗆 F Days Nov 29, 062-03-6886 Director 1916 Connecticut Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21702 USA 6678 Meadowside Drive 12. Was Decedent Ever in U.S. Armed Forces?
1 △ Yes 2 □ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 K Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ho Specify: white "natural". Specify: Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) New York City marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Police Officer 12 Police Department Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H is marked ot ပ္ Augusta Korfhage Alice Korfhage Hans Steinheimer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 6678 Meadowside Drive, Frederick, Maryland 21702 and 2 s Health a Robert Steinheimer - Son item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any injury or ot Date cemetery, crematory or other place)
Resthaven Memorial 1 X Burial 2 Cremation 3 Removal from State 1-12-2011 Frederick, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 21702 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Retween Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying a consequence of Examir g physician and is the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical certificate be attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Year Day Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should neec 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? nas autopsy certificate 1 Yes 2 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. injury Matural 5 Pending work? 2 Accident
3 Suicide Investigation 2 🗆 No the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours 🛩 🚾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number MDD16428 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21701 300 W. Ninth Street, Frederick, Maryland Casper Cline, MD31. Date filed (Month, Day, 32. Registrar's Signature State Cercina

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month SHERMAN RAYMOND NORMAN SR 3,15A M Medical Facility Name (if not institution, give street and number) **Examiner** or Location of De 4c. County of Death ICOMICO If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
NEW YORK 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year MAR 16 / Days Months Min 1 **X** M 2 □ F 67 Director 222-30-3597 Usual Residence of Decedent or 28a-f show be notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits DE SUSSEX LAUREL 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? event, the Medical Examiner must be Funeral I items 23a 9729 LOBLOCLY AUE 19956 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. ō b 1 Never Married 2 Married hours after 1 Yes 2 No Specify: "natural". 3 Widowed 4 N Divorced Specify: WHITE Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SALESMAN should be filed with and Mental Hygien is marked other th 8 AUTO PARTS Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ SHERMAN RAYMOND ESTHES MILLER traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 RAYMOND N. SHERMAN TR 509 BROAD HOUSTON Important: If item 2 any injury or other 1 once. 57. Itimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State ₽ 1 🗆 Burial 2 🕱 Cremation 3 🗆 Removal from State CAPITOL CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) -10-11 DOUER Signature of Funeral Service 22. Name and Address of Facility POB 502 FUNERAL HOME FLEISCHAUER GREENWOOD DE 19950 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year Pregnant at time of death 1 Yes 2 9 Unknown 2 No 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown cate has been signated by page 2 should by 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 2 X No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending injury Accident Suicide Investigation Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined within 24 hours a To the Funeral C Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month. Day, Year) 01-09-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREGORIO 90 5302 CHINABERRY DR., SALISBURY, MD 21801 State Registrar

Robert Martin Schelhouse

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible?

 -)
State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate	of Death	Reg. N	No.	
Physici edical Exam		Decedent's Name (First, Middle,Last)		2. Date of Death Month Da January 4, 20		3. Time of Death 1500 hrs
		4a. Facility Name (if not institution, give street and number) 7810 Clark Road # C 68	4b. City, Town, or Location of Deat Jessup	th	4c. County of Death Anne Arundel	78.1
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 120-58-(57) 1 M 2 F 58	y) If Under 1 Year If Under 24Hr Months Days Hours Mi		M/DD/YYYY) 9. Birtl Foreign Cou	
Maryland 28a-f show any d at once.	ctor	10a. State 10b. County 10c. City, Town or Lo	Ocation JESSUP	1100	Citizen of What Coun	10d. Inside City Limits 1 Yes 2 No
th the Ma 23a or 28 notified a	Il Director	7810 CLARK RD. #C-68	20794	10g. t	U.S-A	•
MOTE, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Fel and Mental Hygiene. Wastural?, or items 23a or 28a-f showns if items 23a or 28a-f showns their if items 71 is marked other than "natural?, or items 23a or 28a-f showns other traumatic event, the Medical Examiner must be notified at once.	by Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced or Dates:	Was Decedent of Hispanic Örigin? (S If Yes, specify Cuban, Mexican, Puert Yes 2 No specify:	o Rican, etc.)	14. Race - Americ White, etc.	an Indian, Black,
(36 hin 72 hours e. than "natur died Exam	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	edent's Usual Occupation (Give kind of ng most of working life. DO NOT use re		p. Kind of Business/Ir	dustry
ore, MD 21215-0036 1 and 2 should be filed within 72 hours after that 2 should be filed within 72 hours after the filed of the filed T is marked other than "matural", her traumatic event, the Medical Examiner.	Be	17. Father's Name (First, Middle, Last) GEORGE B. Schelhouse	CHANIC 18. Mother's Nam ShirkEy	MAE Y	en Surname)	ono p
MD 2. Ind 2 should salth and M cm 27 is marran	To	Christopher Schelhouse, SON 7810	ailing Address (Street and Number or	Rural Route Number		, ,
Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 injury or other traus		1 Burial 2 Cremation 3 Removal from State crematory of	sposition (Name of cemetery, or other place)	7 Date 20 -7-11 C	c. Location - City or 1	own, State
	(MONULU MONULU	22. Name and Address of Facility DA	MOSANEAM.	MT. 2112	HOME
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not ent failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):		or respiratory arrest,	shock, or heart	Approximate Interval Between Onset and Death
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause				
uted ud ransit	l Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			-10	
760, icate be executed physician and the burial - transit	Medical	UNPENDED AMENDED				
C. Box 6876 that the death certificat ned by the attending phy detached for use as the	Physician/M	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1	Fetal death 3 Ectopic pregn		23d. Date of delivery Month Di	ay Y ear
5, P.O. I	ě	Part II. Other significant conditions contributing to death but not resulting in the	he underlying cause given in Part I.	_	o use contribute to the	
cords law request bear a should	Completed			24a. Was an autopsy performed	24b. Were auto	opsy findings available impletion of cause of
Vital Recysician: The his certificate director, page	o Be	25. Was case referred to medical examiner? 1. ✓ Yes 2 No	26.Place of Death (Check	only one)	dence 6 🗸 Other	Scene
Sion of Variending Phydeath. stor: After the yethe funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation Jan 4, 2011 28b. Time 28a. Date of Injury FOUND: FOUND: FOUND: Jan 4, 2011 0250 hrs	of Injury 28c. Injury at Work?	28d. Describe how Subject shot se	injury occurred	
Division spital or Attence tours after death neral Director: filled in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s (Specify) Mobile Home	treet, factory, office building, etc.	or Town, State)		al Route Number, City
Divis To the Hospital or A within 24 hours after To the Funeral Dire	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death or one) 2 Wedical Examiner: On the basis of examination end/or invest and manner stated.	tigation, in my opinion, death occurred	at the time, date and	place, and due to the	cause(s)
	2	29b. Signature and title of certifier	29c. License number O.C.M.E.		d. Date signed (Mona	th, Day, Year)
34		30. Name and address of person who completed cause of death (Item 23e) Ana Rubio MD. Assistant Medical Examiner 900 W. B	altimore Street, Baltimore, M	D 21223		
St Regis	ate trar	JAN 20 2011 /2				
DHMH 17 Rev 1/2 DCME 2006	001	OGMS	NAL			

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 2011 11:53 ₽^M Josephine Fornari Smith Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Independence Court Prince George's Hyattsville Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. 1 M 2 ST F Hours 03/07/1926 174-26-5536 84 Director Yrs. Italy Usual Residence of Decedent 28a-f shov ral", or items 23a or 28a-f sho Examiner must be notified at Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's Temple Hills 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5226 Hagan Road 20748 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinane. þ 1 Never Married 2 KMarried 1 ☐ Yes 2 XXNo If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2x No Specify Specify. Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) In Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Anna Anthony Fornari Coletta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Milton F. Smith / Husband 5226 Hagan Road Temple Hills, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1xx Buriai 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 1/8/2011 4 ☐ Dogration 5 ☐ Other (Specify) Clinton, Maryland 21. Signature of Funeral Service Licer 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland alas 23a burt 1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Disease or imjury Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 X No Pregnant at time of death 5 Other (specify) Month Day Year 1 ☐ Yes 2 2 9 ☐ Unknown the a 9 Unknown Division of Vital Records, P.O. 5 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s performed' Yes 2x X No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6xxother Specify Living Hospital မ 1 🗌 Yes 2 **X** XNo Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1XXNatural 5 Pending 1 🗌 Yes ☐ Accident I Director: / d in by the f Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination arrows investigation, in this opinion, beautiful and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

DHMH 17 Rev 7/2009

only one) 29b. Signature and title

certifie

Frank Ryan

JAN 0 7 2011

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

11701 Livingston Road

32. Registrar's Signatu

D 19431

#103

29d. Date signed (Month, Day, Year)

01/05/2011

Ft. Washington, Maryland 20744

DHMH 17 Rev 7/2009

State

Registrar

Vital

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Division

w

ALAN R. SEGAL M.D. 1500 FOREST GLEN ROAD SILVER SPRING, MARYLAND

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32. Regist

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Date filed (Month, Day, Year

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JANUARY 3, 2011

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinar must be restrict an once. Baltimore, Maryland 21215-0036

> **Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

9	3 Widowed 4 Divorced	Year or Dates:					opcomy.	Vhite					
Be Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Decedent	's Usual Occup	ation during most of working	16b.	Kind of Busines	s/Industry					
dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		Worker	1)		Social N	Work					
9	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)												
To B	Russell Andrew	Russell Andrew Wood Ruth I. Chriss											
	19a. Informant's Name/Relationship	(Type. Print)	19b. Mailing A	ddress (Street	and Number or Rura	l Route Number, City	or Town, State	, Zip Code)					
	Ruth I. Wood / M	other	11906	Pheasan	t Tr., Ha	gerstown,	Marylan	nd 21742					
	20a. Method of Disposition	20b. F	Place of Disposition cemetery, cremator	n (Name of	Di	ate 20c.	Location - City of	or Town, State					
	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Themoval from State	-	-		/2211 -							
	21. Signature of Funeral Service Lice	5III.	LISBURG	Gremat ame and Addre	ory: 1/11	/2011 Sm:	thsburg	g, Maryland					
	21. Signature of Pulleral Service Lice	ise			1101	st Haven]							
	Low Z.				ylvania A		stown,						
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a	cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last Due to (or as a consequence of):												
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ysi	9 Unknown												
F P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute												
Completed by Physician/Medical Examiner		1 ☐ Yes	s 2 No 3 Probably 4 Unknown										
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g						24a. Was an autopsy	prior t	autopsy findings available o completion of cause of					
ပ္ပြဲ						performed? 1 □Yes 2 ☑1	death' lo 1 ☐ Ye	? es 2□No					
3e	25. Was case referred to medical examiner?				26. Place of Death	(Check only one)							
0	1 Yes 2 → No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	DOA Oth	er: 4 🗌 Nursing Hon	ne 5 Residence	dence 6 ☐ Other (Specify)						
Ë	27. Manner of Death 1 ■ Natural 5 ■ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injur Worl	y at 2	8d. Describe how in							
atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio				Yes 2 □ No								
ij	3 Suicide 6 Could not b		ome, farm, street,	factory, office	2	8f. Location (Street	and Number or	Rural Route Number,					
Medical Certification: To Be	4 ☐ Homicide determined	building, etc. (Specia	y)			City or Town, State)							
al	29a. Certifier Certifying P	hysician: To the best of my kno	wledge, death oc	curred at the ti	me, date and place, a	and due to the cause	(s) and manner	as stated.					
dic	(Check only 2 Medical Examone)	miner: On the basis of examina and manner stated.	ation and/or invest	igation, in m y o	ppinion, death occurre	ed at the time, date a	nd place, and d	ue to the cause(s)					
Ž	29b. Signature and title of certifier			29c. Licens	e number	29d. [ate signed (Mo	nth, Day, Year)					
	\	10.1		D21	457	1-	-11-2	211					
	30. Name and address of person who	completed cause of death (Item	n 23a) /Tuno Brin	+)				`					
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DHMH 17 Rev 1/2001

State Registrar

32. Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Stine Jean Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Cumberland WMHS-RMC If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex Country) MD **Funeral** 1 □ M 2 □ ¥ Months Days Hours May 17 215-34-2425 Director 73 Usual Residence of Decedent rral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. ant if ifee 27 is marked other than "natural", or items 23a or 28a-f sho ant if item 27 is marked other than "natural", or items be notified at ury or other traumatic event, the Medical Examiner must be notified at Director Cresaptown MD Allegany 1 ☐xYes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21502 USA 14802 Vermont Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian. 11 Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐ XNo Maryland 21215-0036 If Yes, Give Year or Dates Specify white 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) own home homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen DeCost ပ္ unknown 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code MD 21502 14802 Vermont Avenue Cresaptown Charles Stine husband Baltimore, 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of Date Department of h
Important: If ite
any injury or ot cemetery, crematory or othe Murphy Cemetery 1 X Burial 2 Cremation 3 Removal from State 1/15/2011 MD Swanton 4 Domation 5 Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA ignature f Funeral Se vice Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Part J. Ehter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine Due to (or as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events use as the burial-trai Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month for 1 Yes 2 been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use coptribute to the cause of death? Completed by 1 Yes 2 🖪 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available 24a Was an autopsy performed? Yes 2 No s certificate has be lirector, page 2 s prior to completion of cause of Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical **Division of Vital** funeral director, Be examiner? Yes Other: 2 🗆 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, 27. Manner of Death 28b Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After Py 5 \square Pending 1 Natural 2 Accident 3 11 2 X No 1 Tyes FEII death. Investigation within 24 hours after death

To the Funeral Director: of the foundated filled in by the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) VERMONT for Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STE-306 CLYMBERI AND, MD ASHKER 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

DX

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene per me, g911,01/21/2011dhb. Certificate of Death Reg. No. 1- For Amend Item 25 Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death 3. Time of Death PAIGE BENJAMIN SPENCE Medical Month-90 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Memorial 4c. County of Death -Q stor Talbot Social Security Number Funeral 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. 8. Date of Birth (Month, Day, 1 🗙 M 2 🗆 F 230-42-7316 9. Birthplace (State or Foreign Director Months Days Min 75 Yrs VIRGINIA Usual Residence of Decedent AN. 20 1935 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a, State Director 10c. City, Town or Location 10d. Inside City Limits MD TALBOT WYE MILLS 1 X Yes 2 No 10e. Street and Number 10f. Zip Code Funeral 10g. Citizen of What Country? 517 WYE MILLS ROAD 21679 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. 14. Race - American Indian, þ 1 Never Married 2 X Married Maryland 21215-0636 Black, White, etc. "natural", Completed 3 Widowed 4 Divorced 1 ☐ Yes 2 🛣 No Specify: Specify WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Page 1 and 2 should be filed within nent of Health and Mental Hyglene. ant: If item 27 is marked other tha traumatic event, the College (1-4 or 5+) 12 -0-GROUNDSKEEPER/FOREMAN Be PROPERTY MANAGEMENT 17. Father's Name (First, Middle, Lest) ည 18. Mother's Name (First, Middle, Maiden Surname) ARTHUR SPENCE MARION POWELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARIE SPENCE/ WIFE 517 WYE MILLS ROAD, WYE MILLS, MD 21679 Baltimore, 20a. Method of Disposition permit. Page 1
Department of
Important: If it
any Injury or o 20b. Place of Disposition (Name of 1 🗌 Burial 2 🕱 Cremation 3 🗌 Removal from State Date 20c. Location - City or Town, State CHESAPEAKE CREMATION 4 Donation 5 Other (Specify) 6, STEVENSVILLE, MD CENTER Signature of Fune al Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Approximate Physician/ Interval Between Onset and Death disease or condition resulting in death) PRONARY Medical MINUTES Due to (or as a consequence of) Examiner ARDIAC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or implury that initiated avants. Examine Due to (or as a consequence of): attending physician and for use as the burial-transit TSPIRATION that initiated events 60 m resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 1 Yes 2 9 Unknown Pregnant at time of death Month 9 Unknown Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? DIABETES HYPERILIPIONMIS Completed 1 No 3 Probably 4 Unknown CAD S/PCABG PIPE SMOKING has 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 0B65171/SUEP performed Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 1 Yes 2 - No Be 26. Place of Death (Check only one) examiner? 1 X Yes 2 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral Certificate: 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural 28d. Describe how injury occurred s after death. 5 Pending injury Accident Investigation 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Location (Street and Number or Rural Route Number, City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29c. License numbe 29d. Date signed (Month, Day, Year)

State Registrar DR JOHN (

31. Date filed (Month

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3. Registrar's Signature

7

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Chinh Tran Month Thi Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death)MHS-Kegional Cumberlana Center HILEGAN medical 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Vietnam 8. Date of Birth (Month, Day, Year) 05/25/1929 **Funeral** 1 □ M 2 🂢 F 631-44-4955 Director 81 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other thaumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany LaVale 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 69 LaVale Court 21502 Vietnam 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Specify: Asian 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Trang Luu / Daughter 69 LaVale Court, LaVale, MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory 01/09/2011 Cumberland, MD 22. Name and Address of Facility Adams Family Funeral Home, P.A. Signature of Funeral Service License 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCARDIAL Physician/ ACUTE disease or condition resulting in death) Medical Examiner CORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of) Completed by Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 I Inknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of page 2 s Hospital or Attending Physician: The law autopsy performed' this certificate 1 ☐ Yes 2 ☐ No hin 24 hours after death.

the Funeral Director: After this certifical

mpleted filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 12 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending work?
1 Yes 2 No Natural injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the within 2.
To the F only one) 29b. Signature and title of certifier 29c. License number Hadhu 3 D 26907 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 925 Bishor Walsh Read, Cumberland, MD 21502 Dr. Harrit Sidhu M. D State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 3,2011 Month **Physician** Rebecca M. Topper January 912 gu /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick St. Catherine's Nursing Home Emmitsburg If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M**XXX** F Director 27,1925 Maryland 220-18-1574 March Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or itams 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 🎗 🗓 No Thurmont Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21788 United States 7711 Blue Mountain Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. ☐ Yes ANNO f Yes, Give 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes x2√2 No Specify: þ 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 l Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Assembly Line Manufacturing 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi and Mental H is marked of Helen R. Myers Jacob Topper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2:
Department of Haalth ar
important: if item 27 is
eny injury or other trau 89 21788 Nancy E. Wiles/daughter 7711 Blue Mountain Rd, Thurmont, MD Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition oe of Disposition (Name of netery, crematory or other place)

1/6/2011

20c. Location - City or Town, State cemetery Emmitsburg, 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Myers-Durboraw Funeral Home Willis Street, Westminster, MD 21157 91 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a co Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (a) a consequence of Examine physician and the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical use as certificete hes been signed by the attending irector, page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Day Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Pther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ۵ 2 No 1 TYes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 Yes 2 No of Vital filled in by the funeral director, 25. Was case referred to medical 26. Place of Death | Check only one examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 X No this 27. Manner of Quath 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending death. 1 | Yes 2 | No М investigation Director 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by 4 Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0018705 30. Name and address of person who completed cause of death (Item 23a) (Type, MK South 310 Emmitsburg acrol 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 301 Luther Thomas Truitt 7:47 AM JAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WORCESTER ATLANTIC GENERAL HOSPITAL BERLIN 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 03/08/1938 Country) Maryland 220-34-9443 72 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Examiner must be notified at Director 1 🔀 Yes 2 🗌 No Snow Hill Maryland Worcester 10e Street and Number 10f Zip Code 10g. Citizen of What Country? Funeral 23a 21863 USA 309 Purnell Street items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. ō ģ 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: white "natural" 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and 2 should be filed within 73 Health and Mental Hygiene. tem 27 is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) poultry truck driver other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ella Davis George Thomas Truitt 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 309 Purnell St., Snow Hill, MD 21863 19a. Informant's Name/Relationship (Type, Print) Virginia Truitt/spouse Jedian Lyvartment of Hea. Important: If item 2, any injury or cett 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 XCremation 3 Removal from State 1/10/2011 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 21. Sig ture Funeral Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 arro nocomon > CFSP 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph_sician/ neumonia disease or condition resulting in death) days Medical Due to or as a consequence of) **Examiner** 9443 Sequentially list conditions. ri any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of: and -transit resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical 220-34 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 2 No 2 CK 1 Yes Division of Vital 25. Was case referred to medical To the Hospital or Attending Physician: Director: After this certific d in by the funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: 2 No Other: 1 🗌 Yes ဂ္ 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu ☐ Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D0063904 USA. 30. Name and address of person who completed cross of death (Item 23a) (Type, Print) Healthway Drive Belin John Giller 31. Date filed (Month, Day, Year) Registrar's Signature JAN 0 7 2011 Registrar

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Clifton Antoin Turr	1	- For State Registrar	State of N	/laryland	-	ment of <i>icate of</i>	Health ar Death	nd Menta	l Hygie		2 Q	de entre production de la constanta de la cons	01366	
Physician Medical Examine	ı/ er	1. Decedent's Name (First, M Clifton A	Turn						Jai	Date of Death Month Day Year January 4, 2011			3. Time of Death 0103 hrs	
		4a. Facility Name (if not instit 3900 Bexely Place	Facility Name (if not institution, give street and number) 3900 Bexely Place					r Location of D	eath		4c. Count	•		
Funeral Director		5. Social Security Number 577-92-2834	6. Sex		ge (In yrs. last t 42	birthday) Yrs.	If Under 1 Ye. Months Day			ate of Birth		Foreig	thplace (State or gn Wash, unitry) D.C.	
te Maryland or 28a-f show any fied at once.		Usual Residence of Deceden 10a. State 10b. Cour MD			10c. City, To		aurel						10d. Inside City Limits 1 Yes 2 XNo	
the Marylanc is or 28a-f sh		10e. Street and Number 9578 Muirk	RD.				10f. Zip Code	20708		10g	g. Citizen of V U.S		ntry?	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 77 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Europeal Disorctor			Married 1 1 Divorced If Yes or Da	, Give Year tes:	? !X No	1	s Decedent of Hies, specify Cuba	n, Mexican, Pu	ierto Rican	etc.)		ite, etc. Bl	nerican Indian, Black, : lack	
5-0036 led within 72 hours tygiene. other than "natur the Medical Exam	nataidilli	15. Decedent's Education (S Elementary/Secondary (0- 1 0	2) C	hest grade co ollege (1-4 or		during mo	t's Usual Occupa ost of working life aborer	e. DO N OT use	e retired)			vat	ŕ	
21215-0036 July be filed within 7 Mental Hygiene. Marked other than is event, the Medica	2	17. Father's Name (First, Mid- Clifton S.	Lean						olyn	Turn	er			
MD 21 d 2 should dith and Me m 27 is ma numatic or	L	19a. Informant's Name/Relation Angelicque			fe)	9578	Address (Stre Muirk	RD. I	Laure	el MD	. 207	708		
Baltimore, bermit. Pages 1 and Department of Heal Important: If iten injury or other tra		20a. Method of Disposition 1 X Burial 2 Crema 4 Donation 5 Other	Specify:	moval from S	crem	natory or oth COln	Mem"l	Cem. 1		11	Suit!	Land		
		21. Signature of Funeral Serv	Hunt			90		eay Si	. N.	W. W	asn,	D.C	. 20011	
Physician Magical Examiner	1	23a. Part I. Enter the disease, failure. List only one cau Immediate Cause (Final disea or condition resulting in death	se on each line se a. Multi) .	ot Wounds	not enter th	e mode of dying	, such as card	ac or respi	ratory arres	t, shock, or h	еап	Approximate Interval Between Onset and Death	
ted Insit	i linii linii	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cau (Disease or injury that initiate events resulting in death) La	se c	(or as a cons										
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eath certificate be attending physici for use as the buri	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Mon 4 Pregnant at time of death 5 Other (Specify) 9 Unknown								23d. Date of Month		Day Year			
ls, P.O. I quires that the en signed by the detache	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use con 1 Yes 2 No 3									B Prob	ribute to the cause of death? Probably 4 Unknown			
Division of Vital Records, P.O. B To the Hospital or Attending Physician: The law requires that the d within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached redicted Certification: To Be Completed by Dr.		25. Was case referred to med	cal				26 Place	e of Death (Ch	_ 1[4a. Was an autopsy perform Yes 2	ed?		topsy findings available completion of cause of	
f Vital Physician: or this certi	Ĺ	examiner? 1 Yes 2 No 27. Manner of Death	Hospita	т пірап		Outpatient	3 DOA	Other ₄ Norway Norwat Work?	ursing Hom	e 5 Re	esidence 6 w injury occu		: Scene	
ion o itending leath. ttor: After the fune	֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	1 Natural 5 P	ending J	Ba. Date of Inju (Month Day,) Ian 4, 2011	(ear)	43 hrs	· · ·	Yes 2 ✔ No	Subje	ect shot	w Injury occu	neu .		
Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the fune	3 Suicide 6 Could not be determined Copecify Parking Lot 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Parking Lot 28f. Location (Street and Number or Rur or Town, State) 3900 Bexely Place, Suitland, MD									ral Route Number, City				
To the Ho within 24 h To the Fu completely		nne) 2 Medicai E	xaminer: On th and m				ed at the time, do							
	2	29b. Signature and title of cer	ifier		5/11))	29c. Licens O.C.				29d. Date sig January 4		nth, Day, Year)	
2 6	1	Name and address of pers Russell Alexander M	ID. Assis	A			V. Baltimore	Street, Ba	ltimore,	MD 2122	23			
State Registra	-	1. Date filed (Month, Day, Yea	Bener	32. Registra	r's Signature	w					-			
DUM 147 D 410004			-	-	./	D. O				001	ME			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Gwendolyn Trader 7:50 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Wicomica nins la leaimal Malkal Contor If Under 1 If Under 24 Hrs. 8. Date of Birth . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F Months Days Hours Min. 172-54-6489 50 Yrs. **Director** Virgińia Usual Residence of Decedent 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 🗆 Yes 2 🎇 No Maryland Wicomico Salisbury ms 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 411 Dorsey Lane 21801 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ò δ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. "natural" Completed 3 Widowed 4 Divorced Black Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 <u>Transportation Driver</u> <u>Shore Transit</u> other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Florence Collins Leroy Trader 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st.
Department of Health an
Important: If item 27 is rany injury or 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sabrina Trader| daughter 411 Dorsey Lane, Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State
Donation 5 Other (Specify) Green Acres 01 | 15 | 2011 Salisbury, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility
Stewart Funeral Home West Rd., Salisbury, Maryland 21801 23a. Part 1. Enter the disease, or complications to be aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Molignan 7 Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause tursease or impury that initiated events. Examine Due to (or as a consequence of): as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe performed? Yes 2 V this certificate 1 Tes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No ၉ in 24 hours after become.

The Funeral Director: After this of an analeted filled in by the funeral differential different 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the P within 2 To the F 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 030690 ,u. 0 2011

Box 68760

P.O.

Division of Vital

DHMH 17 Rev 7/2009

Registrar

5-lisbur-

Corroll 58.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.O

legistrar's Signature

MARTIN

E

Jones

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of M	-	partment of H ertificate of D		•					
			Decedent's Name (First, Middle, L.)	ast)		oranoato or b	Juli	2. Date of Dea		3. Time of Death			
	Physicia Medic		SHIRLEY M.	TUCKER	Jan.	$\overset{\text{Day}}{3}$, $20\overset{\text{Ye}}{1}$	1 12:15A M						
	Examin		4a. Facility Name (if not institution, g.	ve street and number)		4b. City, Town, or	Location of Death	1	4c. County of D				
-	,		9001 Lake Lar		je (In yrs. last birthda)	Largo If Under 1 Year	If Under 24 Hrs.		Prince	Prince Georges			
	Funeral Director		5. Social Security Number 225-52-9922 Usual Residence of Decedent	Birthplace (State or Foreign Country) NC									
	yland -f show ed at	Funeral Director	10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits			
	e Mar r 28a notifi	į	VA Fairfa	X	Alexan					1 🗆 Yes 2 🔀 No			
	ith the	<u>a</u> [D		10f. Zip Code			10g. Citizen of What	t Country?			
	ath w	la la	8030 Fordson	12. Was Decedent	Ever in U.S. 11	22306	nanic Origin? (Sp	acify Vas or No-	USA				
Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed by F	1 ☐ Never Married 2 ☐ Married 3 🌠 Widowed 4 ☐ Divorced	Armed Forces?		3. Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 X No		Rican, etc.)		merican Indian, /hite, etc.			
0-10	hour natur lical	le le	15. Decedent's	Education		cedent's Usual Occupa		7	16b. Kind of Busine				
21	iin 72 ie. han "	Ę	(Specify only highest Elementary/Seconday (0-12)	College (1-4 or s	lifa	ve kind of work done do DO NOT use retired)	uring most of worl	king					
7	led within Hygiene. other thar ent, the M	BeC		2	Proc	urement (U.S. Gov	rernment			
and	e filed tal Hy ed oth event	10 B	17. Father's Name (First, Middle, Las	t)				, , ,	Maiden Surname)				
ž	should be file h and Mental h 7 is marked o raumatic eve		Leroy Hayes	(Time Defeat)			Ruby Mo						
Ma	2 sho th an 27 is traui		19a. Informant's Name/Relationship Seena Tucker-W	illiams7	nter 196. Ma	ailing Address (Street a.				Zip Code) a, VA 22310			
	and 2 s Health Item 27 other tra		20a. Method of Disposition		20b. Place of Dis	position (Name of	· ·	Date	20c. Location - City				
JO L	Page 1 ment of ant: If it		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		cemetery, c	rematory or other place nfort Cem			Alexandr	•			
Baltimore,	2445		21. Signature of Funeral Service Lice		1	22. Name and Address							
ä	permit Depar Impor any in		> Nelon E S	Luy_		814 Fran	klin St	Alex	andria,	VA 22314			
			23a. Part 1. Enter the disease, or co shock, or heart failure. List only	mplications that caused one cause on each line	d the death. Do not e e.	nter the mode of dying	, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death			
8	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)		a. Lung Cancer Due to (or as a consequence of):								
-	Examiner	ı	resulting in death)	Due to (or as	a consequence of):								
		ĕ	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):								
	ted Insit	Examiner	Cause Disease or impury							.24			
	execu in and ial-tra		that initiated events resulting in death) Last	Due to (or as	a consequence of):								
0	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Medical		d									
8760	tificat ng ph as th	Med	IF FEMALE:										
x 68	ath certific attending for use as	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth	of pregnancy 2 Fetal death 3	☐ Ectopic pregnancy	,		23d. Date of	,			
Вох	deat the at ned fo	Physician/N	1 Pes 2 XNo 9 Unknown	4 □ Pregnant a 9 □ Unknown	t time of death 5	Other (specify)			Month	Day Year			
P.O.	that the desired by the stacked is		Part II. Other significant conditions	contributing to death b	out not resulting in the	e underlying cause give	en in Part I.	23e. Did to	hacco use contribute	e to the cause of death?			
S,	signe d be o	d by								Probably 4 Unknown			
ğ	require been sign	Completed	,			-		24a. Was a		autopsy findings available			
ecc	The law ate has page 2	ᄩ	****					autop perfor	sy prior med? death	to completion of cause of			
<u>~</u>	ician; The certificate ector, pag	ادہ ا	25. Was case referred to medical		-		ce of Death (Chec	1 Yes	2 🔀 No 1 ⊔	Yes 2 No			
Division of Vital Records,	ysician; is certific director,	To B	examiner? 1 Yes 2 No	Hospital:	ent 2 ER/Outpat	Other	4 Nursing H	ome 5 Resid	ence 6 X Other (St	oecify) Son's Residen			
of	ding Ph th. After thi funeral		27. Manner of Death	28a. Date of inju (Month, Date	ry 28b. Time	of 28c. Injury	at	28d. Describe ho	ow injury occurred				
on	Attending or death. ector: After by the funer	lica	1 😾 Natural 5 🗌 Pending 2 🗋 Accident Investigat 3 🗆 Suicide 6 🗎 Could not	ion	,,,,		∕es 2 □ No						
Visi	or Att after d Directs in by t	Certificate	3 □ Suicide 6 □ Could not 4 □ Homicide determine		ury - At home, farm, s c. (Spec <i>ify</i>)	street, factory, office		28f. Location (Sa	treet and Number or n, State)	Rural Route Number,			
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	To the Hospital or Attent within 24 hours after deat To the Funeral Director: completed filled in by the	Medical	(Check 2 🛄 Medical Exa		xamination and/or inv	estigation, in my opinior	n, death occurred a	at the time, date ar	nd place, and due to ti	he cause(s) and manner stated.			
	To the within To the comple	Σ	only one) 3 L Certifying M 29b. Signature and title of certifier	se Practioner: To the	best of my knowledge	29c. License			cause(s) and manner 29d. Date signed (Mc				
	->-0		1 DAY	1	=	1000	70107		01-66	-7011			
Ţ	M		30. Name and address of person who	completed cause of d	eath (Item 23a) (Type	Print)	1-10 6						
2	_ /		Ivan Zama, MD,				200, La	rgo, Mi	D 20774				
	Stat		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature				· · · · · · · · · · · · · · · · · · ·				
	Registra	ar	JAN 0 7 2011 🔏	energy Da.	A COLLEGE								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Amended item For State Registrar # 10e, per F.H., 1/5/11, BA Certificate of Death WCHD Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month 1/2/2011 **Physician** Richard R. Udzielak 1026 M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ocean City Worcester 1002 Baltimore Ave. 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day,) 9/1/1937 9. Birthplace (State or Foreign Country) NJ **Funeral** 1**X** M 2 □ F Months Days Hours Min. 73 Director 152-26-8552 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene, instural, or items 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinator and once. Director MD 1 ☐ Yes 🎗 🛣 No Ocean City Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1002 Baltimore Ave. USA Funeral 10334 Waltham Rd. 21842 death 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1. Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 No <u>ک</u> Specify Specify 3 Widowed Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Superintendant GM 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Udzielak Blanche Sanack ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10334 Waltham Rd. Ocean City, MD 21842 Tom Udzielak 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 1st State Crematory 1/7/2011 Millsboro. DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Functal Sery 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia - Cau e (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): executed and burial-trar Due to (or as a consequence of): P.O. Box 68760. attending physician the death certificate be Physician/Medical the as use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>Ş</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown been s Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s was a.. autopsy performed? was 2 **X**No has certificate 1 ☐Yes 2 ☐ No 1 □Yes Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) Hospital: 1 XTYes 2 □ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA after death. Director: After this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or To the Hospital or within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s). Medical 29a Certifier cal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Sig ature and title 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sallshun BA 20+1 mis 100 E. Carroll Jt 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 05 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Pay 201 Year January Margaret Mae Ullrich 7:50 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death College View Center Frederick Frederick If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Y 1 □ M 2 🖾 F Months Days Hours Min. 69 Director 1940 Pennsylvania 219-46-8105 Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Frederick Brunswick 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 1043 Orndorff Court 21716 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 _{Specify:}White 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Cook Truck Stop Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ George Eckenrode Emma Grushon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i Jo Ann Gibbons / Sister 27 East 3rd Street, Apt. 3, Frederick, MD 21701 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Jan. 1 Burial 2 X Cremation 3 Removal from State Resthaven Crematory 4 ☐ Donation 6 ☐ Other (Specify) Frederick, Maryland 2011 21. Signature of Funeral Solvice Licensee 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, 23a Part 1. Enter the dise shock or heart failur se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ and NOMYO disease or condition Medical resulting in death) to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Exami burial-transi and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon 5 Other (specify) Month 1 Yes 2 100 the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law r within 24 hours after death. To the Funeral Director: After this certificate has b autopsy 2 🗌 No a No Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) 1 Yes 2 No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) I Director: After the in by the funeral 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier MI D60417 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tolonson DV, Frederick 65 0 temen Shall 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN Registrar

DHMH 17 Rev 7/2009

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 January Jack E. Ward 0913 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Ceci1 133 Black Oak Drive E1kton . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 X M 2 🗆 F JAN 1. 1934 Maryland Director 220-28-1020 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Ceci1 E1kton 1 Tes 2 X No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ms 23a or must be Funeral 133 Black Oak Drive 21921 United States 12. Was Decedent Ever in U.S. Armed Forces? 1953 1 X Yes 2 No. 1955 If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: "natural" Completed 3 Widowed 4 X Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than " College (1-4 or 5+) Elementary/Seconday (0-12) Certified Public Accountant Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) f Health and Mental Hitem 27 is marked of other traumatic even မ Mildred Catlin Melvin Ward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Whiteside/Companion 133 Black Oak Drive, Elkton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 D Burial 2 X Cremation 3 D Removal from State Januar Important: If any injury or once, Family Cremation Service 2011 4 ☐ Donation 5 ☐ Other (Specify) Wilmington, DE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, MD 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) una Medical Due to (or as a consequence of) 2 meder Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): n signed by the attending physician and Id be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Dav Year Unknown by 1 P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Kunknown bee 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s performed? Yes 2 No 2 K No 1 🗌 Yes Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 **X**-No Other: 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death e Hospital or Attending Ph 124 hours after death. e Funeral Director: After th 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatur

/5→ / VA State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

John A. Billon,

M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Year Katrina Wills 12:24 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death University Manyland Medical Center altimore Of 5. Social Security Number 220 – 90 – 5483 Sex 1 □ M 2 X F 8. Date of Birth (Month, Day, Year) 10-27-75 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min. Hours Maryland **Director** 35 Usual Residence of Decedent ms 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland **Funeral Director** 1 Yes 2 No Silver Maryland Montgomery Spring 10f. Zip Code 10g. Citizen of What Country? Page 1 and 2 should be filed within 72 hours after death with 609 Kenbrook Dr 20902 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 0 Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Specify: "natural", 3 Divorced Year or Dates Black is marked other than "natural aumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Day Program Volunteer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ၉ Andrew Wills Wilhemina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coop) 7 9 4 8152 Washington Blvd, Unit256, Jessup MD Wilhemina Smith/Mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ō Department of Important: If it any injury or o cemetery, crematory or other place, 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Resurrection 1 - 13 - 11MD Clinton Signature/of Funeral Service Licenses 22. Name and Address of Facility Adams Funeral HomePa, Aquasco Md 20608 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ bacteremea disease or condition Medical resulting in death) **Examiner** BCCLL Lympho blastic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequent e of): Due to (or as a consequence of): resulting in death) Last burialattending physician Physician/Medical certificate be 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery Box (3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Month Day Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed? Yes 2 No **Division of Vital** To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 110 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred I or Attending F after death. work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) e Funeral L Medical 29a. Certifier Leartifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medica! Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 18932 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wy in Hadu Maryland Medical 22 South Greet State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3:26ам Norman Warshawsky Medical /01/2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 3601 11th Street Chesapeake Beach Calvert Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🕅 M 2 🗆 F Hours Director NY 082-34-3240 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10h County within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Chesapeake Beach MD Calvert 1 🗆 Yes 💥 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 20732 3601 11th Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc 1 Never Married 2 X Married þ Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 XXIo Specify: If Yes, Give Completed 3 Widowed 4 Divorced White Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Meaone. Elementary/Seconday (0-12) College (1-4 or 5+) Sales Supplies Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Florence Stecker Harry Warshawsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 3601 11th Street, Chesapeake Beach, MD 20732 Carol Warshawsky/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory 01/03/2011 Clinton, MD 21. Signature of Fur eral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. Lisa M Mounts 8125 Southern Md Blvd., Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death BLADDER RCINOMA URINARY disease or condition Medical resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to for de a consequence of, cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month 9 Unknown g 🗆 Unknown ed by t detach signed k d be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DISEASE ARTER 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has ral director, page 2 autopsy 1 Yes 2 No Yes 24 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? ဂ္ဂ 1 🗀 Yes Other 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 D Nursing Home 5 Residence 27. Man of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? After 28d. Describe how injury occurred 5 Pending Natural Accident 1 Tes 2 No Investigation 24 hours after deatl Funeral Director; Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 2 Medical Examiner: On the basis or examination allowed investigation, in this opinion, south of the cause of the cause of an anner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD. 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSP RD. PRINCE FREDERICK MD 20672 Lew MUNSAI- M.D SINTE 300 ANWAR 130

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JAN.

32. Registra s Signature.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 01/02/2011 Year Michael Andrew Walker 12:47 pm Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death <u>Calvert County Nursing</u> Center Prince Frederick Calvert **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Hours 1 🕅 M 2 🗆 F Days (Month, Day, Year) 12/24/1964 Director 46 214-90-3997 DC Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Calvert Dunkirk 1 ☐ Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12140 Palisades Drive 20754 U.S.A. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1XXNever Married 2 Married Black, White, etc. þ 1 ☐ Yes 2 🗓 No If Yes, Give Maryland 21215-0036 e filed within 72 hours after ital Hygiene. ed other than "natural", o 1 ☐ Yes 2 🛣 No Specify. Completed 3 Divorced 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) N/A Never Worked Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F. Charles E. Walker permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Mary Catherine Nemir 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12140 Palisades Drive, Dunkirk, MD 20754 Mary Catherine Walker/Mother 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory 01/03/2011 Clinton, MD Signature of Fune al Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. Lisa M. Mounts 8125 Southern Md Blvd., Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical r as a consequence of: Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 _ Ectopic pregnancy 5 Other (specify) Pregnant at time of death Month signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed certificate has been si rector, page 2 should 2 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn Yes 2 No 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: ပ 1 🗌 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 No Accident Investigation 6 🗌 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State 24 hours Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 2011 30. Name and address of person who completed cause of ceath (Item 23a) (Type, Print) #310 20678 31. Date filed (Month, Day, Year) 32. Registrare Signature State JAN Registrar

DHMH 17 Rev 7/2009

Examiner and Division of Vital Records, P.O. Box 68760 has Hospital or Attending Physiclan: 24 hours after death. Funeral Director: After this certifice

death with the Maryland

Baltimore, Maryland 21215-0036

signed by the attending physician be detached for use as the buria To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

> State Registrar

Medical

29a. Certifier

nes

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) JAN 0 4

32 Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

1 crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

C10007

29c. License number elaware

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Year

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Marine A	<u></u>	Н	12030 Looking 5. Social Security Number	oill		7. Age (In yrs.	4b. City, Town, or Location of Death Keymax (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.								eder:		
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Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relation				19b. Mailir	g Address	(Street a	nd Numbe	r or Rural	Route Numbe	er, City c	or Town, St		ode)	
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Baltimore,	permit. Page 1 Department of Important: If i any injury or o		21. Signature of Funeral Segvi			mea	dow Br							tmins		MD Chapel	
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	nysician/ Medical		23a. Part 1. Enter the disease shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death)	or com st only c	a	caused the dear on line. for as a conseq	RStih	6. 1	of dying		cardiac or		rrest,			Approximate Interval Between Onset and Death	
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Box 68760	Within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burneral director.		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1										23d. Date of delivery Month Day Year				
P.O.	requires that the de been signed by the should be detached	by Ph	Part II. Other significant cond	itions co	ontributing to de	eath but not res	sulting in the ur	nderlying ca	use give	en in Part I.		23e. Did to	obacco	use contrib	ute to the	cause of death?	
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Division of Vital Records,	aw red as bee 2 sho	Completed	hype II	DIA	seles	melli	trus					24a. Was		24b. We	ere autops	sy findings available	Ð
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ıta	sician: The law certificate has b irector, page 2 s	Be	25. Was case referred to medic examiner?		Hospital:				_	ce of Death	(Check o					Daughter	1 _S
ر ک	r this eral dir	욛	1 ☐ Yes 2 ☑ No 27. Manner of Death		1 🔲	npatient 2 of injury	ER/Outpatient 28b. Time of			4 ∐ Nur						Residenc	<u>e</u>
uC	ath. r: Afte e fune	icate	1 Natural 5 ☐ Pen 2 ☐ Accident Inve	ding stigation	(Mont	h, Day, Year)	injury	M 201	c. Injury : work? 1 🔲 Y	at ′es 2 □ I	- 1	d. Describe h	iow injur	y occurred			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ CHARLENE DENISE WINGLER Month 16:44 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CARROLL HOSPITAL CENTER CARROLL WESTMINSTER, MD | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Jan. | 31 , 1960 Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🔀 F Director 215-74-9025 50 Usual Residence of Decedent show 10a. State 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits 28a-f MD Carroll Manchester 1 Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 23a Funeral 2405 Bachman Valley Road 21102 U.S.A. or items death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. ģ 1 X Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Completed 3 🗆 Widowed 4 🗆 Divorced Specify. White other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working than life. DO NOT use retired) College (1-4 or 5+) 5 ± Elementary/Seconday (0-12) d Mental Hygiene. marked other tha Registered Nurse Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Edward Wingler Gloria T. Bull and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Stephanie A. Wilking/Exec. 810 Upland Road, York, PA 17403 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Jan^{Date} 18 Mt. Cemetery crematory or other comments. 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2011 Parkton, MD 21. Signature of Funeral Service I censes 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 11. 24 N. Second St., New Freedom, PA 17349 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ Probable acute m 40 canda Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): s been signed by the attending physician should be detached for use as the burial by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No \square Pregnant at time of death Day 1 Yes 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? L obe Completed 1 ☐ Yes 2 Probably 4 ☐ Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work ☐ Accident ☐ Suicide 1 🗌 Yes 2 🗌 No Investigation within 24 hours after deat To the Funeral Director. 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 [Ceglifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title o 29d. Date signed (Month, Day, Year) D0026575 10 2011 121 n who completed cause of death (Item 23a) (Type, Print) 30. Name and address of p 21030 10155 YORK RD STE 200 COCKEYSVILLE, JAN 2 4 2011 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ ANUAL Y DG PM Medical Name (if not institution **Examiner** give street and number NG 4b. City, Town, or Location of Death County of Death NATIONAL 8. Date of Birth (Month, Day, Year) Aug. 8, 1925 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Funeral 9. Birthplace (State or Foreign 1 □ M 2 🖾 F Days Hours Min. 579-30-0867 85 Washington, DC **Director** Yrs. Usual Residence of Decedent 10a. State 10b. County the Maryland 10c. City, Town or Location Director 10d. Inside City Limits notified 28a-f 1 Tyes 2 X No Maryland | Montgomery Damascus 10e. Street and Number ö 10f. Zip Code iral", or items 23a or Examiner must be 10g. Citizen of What Country? Funeral within 72 hours after death with 10931 Longmeadow Drive 20872 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2XX No Specify; "natural" Completed 3 ☑ Widowed 4 ☐ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Office Manager 8 Law Office ulth and Mental Hygie 27 is marked other r traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Page 1 and 2 should be George Fallon Manitta Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a 10931 Longmeadow Dr., Damascus, MD 20872 Nancy Austin / Daughter other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Jan. Tale, cemetery, crematory or other place ö 1 Burial 2 X Cremation 3 Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Crematory 2011 Frederick, Maryland 22. Name and Address of Facility
Resthaven Funeral Services, Skkot Cody P.A.
2501 Catalia Mountain Hwv. Frederick, MD 21701 21. Signature of Fundal Service Censee 23a. Part 1. Enter the disease replications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Very only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ BRONCHO-INELMONIA me was Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and -transit that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year signed by the a g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ARTERY CORONARY 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown been HYPO THYROIDISM 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has e 2 autopsy performed? page DEMENTIA this certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 13 STh D.30469 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) PARKWAY # 308, MD-21045 COLLITBIA, 31. Date filed (Month, Day, Year) 32. Regist ar's Signature State back Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 PM George Wright Winfree 1:17 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 8293 Memory Gardens Lane Hebron Wicomico Social Security Number If Under 1 If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8 Date of Birth **Funeral** 1 X M 2 □ F Months Days Hours Min (Month, Day, Year) Director 218-16-6344 Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No MD Wicomico Hebron 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 8293 Memory Gardens Lane 21830 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ò þ 1 Never Married 2 Married 1943 Baltimore, Maryland 21215-0036 and Mental Hygiene.
is marked other than "natural", If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 XWidowed 4 ☐ Divorced Specify: 1973 Completed White 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Electronic Technician U. S. Navy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) permit. Page 1 and 2 should be fili.
Department of Health and Mental |
Important: If item 27 is marked c
any injury or other traumatic eve မ Alfred George Winfree Myrt1e Perine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) son-in-Frederick M. Ward III -1aw 8293 Memory Gardens Lane, Hebron, Maryland 21830 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Paul's Epis. Cem. 1-13-2011 Hebron, Maryland 22. Name and Address of Facility Bounds Funeral Home Main Street. Salishury, Maryland 21804 23a. Part 1. Enter the disease, or compli-shock, or heart failure. List only or ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) physician and s the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death signed by the at Id be detached for Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not ∤esulting in the underlying cause given in Part I. 23e. Did topacco use contribute to the cause of death? þ DON Yes 2 🗆 No 3 🗆 Probably 4 🗆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed' certificate Yes 2 No 2 Yes director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 👿 No Other: 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death. To the Funeral Director, After this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident completed filled in by the Investigation 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certific 29c. License number 116

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State

Registrar

address of p

30. Name and

31. Date filed (Month

ompleted cause of death (Item 23a) (Type, Print)

32 Registrar's Signatur

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Edith Mary White l2:45 A 4, 2011 Jan. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Heartland Health Care Center Hyattsville Prince George's If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday **Funeral** Days 1 ☐ M 2 🖾 F 92 579-44-5725 Culpeper Co, Director Jan. 1919 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20783 6500 Riggs Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Black 1 ☐ Yes 2 ☐ No Specify. Specify: þ 3₺ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper Private Homes : 1 and 2 should be filed wi Health and Mental Hygier tem 27 Is marked other th 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florine Thompson ဂ Daniel Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra Jean Van Duzer / Friend 1077 Largo Road, #109, Upper Marlboro, MD 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Riverdale Baptist Cemetery 1/7/2011 Largo, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Fungral Service Licensee 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Hans 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Que to (or as a consequence of): Examiner browseule. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner prolipioseule- Discuso burial-transi Physician/Medical om the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ρ Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s Loude 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 1 Inpatient this funeral 27. Manner of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t Certification: 5 Pending investigation Iniury 1 ☐ Yes 2 ☐ No 2 Accident Director: in 24 hours.
The Funeral Director of filled in by the 6 Could not be determined

death certificate be executed Box 68760, physician P.0. ed by the a detached f signed t Records, certificate has Division or Vital Physician:

the Hospital or Attending

death.

72 hours after

Baltimore, Maryland 21215-0036

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29h Signatur	e and title of cer	rtifior
200. Olgilatui	e and the or ter	ullei
N .	11/1/1/	1 1 1
	Bl. 1 1 10-20	

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only

29d. Date signed (Month, Day, Year)

in ixa 4701 Randalph Rd # Zab. Rockiila Mb 20852

State Registrar

Medical

DHMH 17 Rev 1/2001

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Jan 8, Physician/ Wilson 2011 Patricia Ann 10:00 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 12828 Knobley View Allegany Cresaptown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD 1 🗆 M 2 🗆 🕱 Min. Hours Mar 29 Director 218-68-2521 60 1950 Usual Residence of Decedent 28a-f shov 10a. State the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Cresaptown 1 □x/es 2 □ No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 12828 Knobley View 21502 USA items 2 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 🗆 Yes 2 🗆 No "natural", 3 Widowed 4 Divorced Completed white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life, DO NOT use retired) during most of working and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked oth any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James Llewellyn Hazel (Mason) Llewellyn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Jennifer Wilson daughter MD 21502 12828 Knobley View Cresaptown 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Scarpelli Funeral Home, P.A. 1/10/201 4 Donation 5 D Other (Specify) Cresaptown MD Şignatur of Funeral Arvice Licensee 22. Name and Address of Facility eral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition MONTH Medical resulting in death) Due to (or as a consequence of Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and as the burial-trar Due to (or as a consequence of): resulting in death) Last signed by the attending physician d be detached for use as the burial Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L. Ferance.

Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tyes 2 No Other: မ 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpa 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide within 24 hours after deatl To the Funeral Director. Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, gearn occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 502 nson who completed cause of death (Item 23a) (Type, Print) and address of be

Registrar

State

SETON DRIVE

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DSON M.D.

32. Registrar's Signature

N 2 0 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10:25A M JAN. 12, 02/011 Year Laverne Elizabeth Washburn Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 4b. City. Town, or Location of Death GENESIS WALDORF CENTER WALDORF Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8 Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🔀 F Months Days Hours 240-22-4227 N Country) 87 2 3 2 2 3 2 1 2 3 2 3 2 3 2 3 2 3 Director Usual Residence of Decedent show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director HUGHESVILLE MD. CHARLES or 28a-f 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 14805 PALE MORNING PLACE U.S.A. 20637 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. þ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🔀 No Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry d Mental Hygiene. marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) AMERICAN TOBACCO CO FACTORY WORKER 12th Health and Mental Hygie tem 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 MARSHALL JENNINGS TALLEY LUCY CORUM Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, RITA WEAVER-DAUGHTER 14805 PALE MORNING PL. HUGHESVILLE, MD. 20637 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) METROPOLITAN CREMATORY 1-13-11 ALEX., VA. Signature of Funeral Service License MQQ479 Nume and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine n any, leading to immediate cause. Enter Underlying Due to (c) as a consequence of Cause (Disease or iinjury the burial-trai that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year 5 Other (specify) g Unknown a \ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🖫 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 autopsy perform 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital 2 XNo Other: Certificate: To 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work Accident 1 \square Yes 2 🗌 No Investigation 24 hours after deat Funeral Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death place and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the I only one) 29b. Signature and title of certifier of person who completed cause of death (Item 23a) (Type, Print) WISOTSKY, MD 12070 OLD LINE CENTER ζΙÞ WALDORF, MD 20602 31. Date filed (Month, Day, State Registrar's Signature Registrar BARRAG

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Marylandi, Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 3, 2011 7:00 a M Levester Ray Youman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Holy Cross Hospital Silver Spring If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. 1 SOM 2 DE Hours (Month, Day, Year) March 27, 1950 Country) Director 573-78-6649 60 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified 1 Yes 2 No MD Calvert Chesapeake Beach 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ō "natural", or items 23a or edical Examiner must be Funeral 3447 Silverton Lane 20732 USA Page 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
ant. If item 27 is marked other than "natural", or items uny or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black. White, etc. 1 Never Married 2 Married by 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Law Enforcement Special Agent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Levester Youman Bessie Lee Washington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13520 Lily Place, Chino, CA 91710 Patricia Ann Youman-McGowan - sister Department of Health Important: If item 2; any injury or other to once. 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory January 8, 2011 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Sewell Funeral Home, P.A. 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ vra Hemorrag disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine Due to or as a consequence of: cause. Enter Underlying Cause (Disease or linjury that initiated events TION APPROVED OF MEDICAL EXAMINER the attending physician and the for use as the burial-transit Due to (or as a consequence of): resulting in death) Last CERTIFIC Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day Pregnant at time of death 2 No 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by neumonia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Respiratory Failure 24a. Was an Were autopsy findings available prior to completion of cause of After this certificate has autopsy death? 1 ☐ Yes 2 ☐ No Yes 2 🗷 No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical examiner?

1 X Yes 2 No. Be 26. Place of Death (Check only one) Hospital Other: ပ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Accident Investigation within 24 hours after death To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a, Certifier 1 👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 32332 103/11 who completed cause of death (Item 23a) (Type, Print) 9801 Georgia 30. Name and address of person Pta 2RW 10 DUresh

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year,

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32. Registra

Silver Spring.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 201^{Year} January Dolores Seena Yalom 1:20 A_M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** College View Center Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** (Month, Pay, Year) ine 4, 1927 Months Days Hours Min 83 Maryland 578-34-5877 **Director** June Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City. Town or Location ral", or items 23a or 28a-f shore Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 ☐ No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2500 Waterside Drive, Suite 216 21701 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married White 1 ☐ Yes 2XX No Specify: If Yes, Give Year or Dates "natural", Completed 3 X Widowed 4 Divorced of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If item 27 is marked any injury or other trees. ပ A. Albert Goldstien Ethel Chusman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melinda Yalom / Daughter 8504 Aragon Ln., Chevy Chase, MD 20815 20a. Method of Disposition Jan. 2011 20h Place of Disposition (Name of 20c. Location - City or Town, State Garden of Remembrance Memorial Park 1 🔀 Burial 2 🗌 Cremation 3 🗎 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Clarksburg, Maryland 21. Signature of Funeral Service Licensee Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, 23a. Part 1 Enter the disc shock, or heart failer se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e. List only one cause on each line. Approximate Interval Between Immediate Cause (Fixe disease or condition resulting in death) Onset and Death Physician/ Due to (or as a consequence of): Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician a the burial-Physician/Medical attending p IF FEMALE: 23h Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month Year Month 2 No ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ρ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page performed death? After this certificate I funeral director, pag 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Kursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending after death.

Director: Aft
d in by the fur ☐ Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one

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Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

DHMH 17 Rev 7/2009

Registrar

State

e and title of certifier

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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29b. Signatu

Hemen

31. Date filed (Month, Day, Year)

29d. Date signed (Month, Day, Year) 1-10-2011

Tolinson Dr Frederick MD21702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2011 Year Robert Harrison Young, Sr. 1, 10:37 January A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7400 Damascus Road Gaithersburg Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 217-30-7311 1 X M 2 □ F Months Days Hours Min $J_{u}^{(Month, Day, Year)}$ 1936 Maryland 74 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No Maryland Frederick Jefferson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3382 Point-of-Rocks Road 21755 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 12. Was Decedent Ever in U.S 14 Bace - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🛣 No If Yes, Give filed within 72 hours after Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than. Elementary/Seconday (0-12) College (1-4 or 5+) Sanitation Technician City of Frederick Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Harrison McKinley Young Ethel Runyon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Robert H. Young, Jr. / Son 4810 Old Swimming Pool Rd., Frederick, MD 21703 20b. Place of Disposition (Name of cemetery, crematory or other place)
Resthaven
Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State Jan. Date. permit. Page 1 and Department of Hamportant: If ite any injury or 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2011 Frederick, Maryland 21. Signature of 5 meral S 22. Name and Address of Facility Resthaven Funeral Services, 9501 Catoctin Mountain Hwy. Skkot Cody Frederick, 23a. Part 1. Enter the decase, o shock, or heart fallure. List Immediate Cause (Final plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death one cause on each line. Physician, disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or impury Examine Due to (or as a consequence of) r Attending Physician: The law requires that the death certificate be executed and -trans that initiated events resulting in death) Last Due to (or as a consequence of) the burialattending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) signed by the a d be detached for Yes 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, cate has been sig page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 Yes 2 No Yes 25. Was case referred to medical Division of Vital director, Be 26. Place of Death (Check only one) examiner? 1 X Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours are death.

To the Funeral Director After this completed filled in by the funeral is 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 📉 Natural 5 \square Pending work? 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check To the I only one) Certifying Nurse Practioner, To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certification 29c. License number MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 UT gant

State Registrar IRR N
31. Date filed (Month, Day,

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			For State		State of Ma	ırylan	-	artmen <i>rtificate</i>			and M	ental Hy	_	0.0.1	1	0.1	007
			Registrar 1. Decedent's Name (First, Middle, Las	t)		Cei	TITICATE	OIL	eatn		2. Date of De	Reg. N	lo.	Dr. of	3. Time o	of Death
	Physicia Medio		Robert	, , , , , , , , , , , , , , , , , , , ,		Sherwood				Yates					ear		48PM
	Examin		4a. Facility Name (if no		street and number)	1.		4b. City,	Town, or	Location of	of Death		4	c. County of	Death		
			COASTA 5. Social Security Nun	Hospice	Jake	yrs. last birthday) If Under 1 Year If Under 2				24 Hrs	0. Data of Bi		Wicomico				
	Funeral Director		212-48-895	54	53.	Yrs.	Months	Days	Hours	Min.	(Month, Day, Year) C			Count	lace (State ry) yland		
	ind show at	۵ ا	Usual Residence of D 10a. State 1	ecedent 10b. County		10c. City	, Town or Lo	cation							10	0d. Inside C	City Limits
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ates 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status1 X Never Married3 Widowed 4		12. Was Decedent Ev Armed Forces? 1 Yes 2 N h If Yes, Give Year or Dates.	er in U.S lo		Was Decede f Yes, speci 1 ☐ Yes 2	fy Cubar	n, Mexican	, Puerto R	ify Yes or No- ican, etc.)		14. Race Black, \ Specify: V	Vhite, e	etc.	
€ 20°	2 hour "natu	plet	(Specia	15. Decedent's Ed fy only highest gra	ducation de completed)		16a. Dece	dent's Usua kind of worl	Occupa	ation urina mosi	t of working	a	16b.	Kind of Busin	ess Ind	ustry	
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Robert S. Y	Page 1 ment of ant: If ii ury or o		1 🕅 Burial 2 🗆		Removal from State	Ce	emetery, crer	natory or ot	her place	· i				t New	•		MD
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	Medical Examiner		resulting in death)	ſ	Due to (or as a	consequ	ence of):	- 1 s			()	J		-		/	
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0	icate be executed physician and s the burial-transit	edical Exa	that initiated events resulting in death) La		c. Due to (or as a	consequ	ence of):										
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. Box 68	or Attending Physician: The law requires that the death certificate be executed after death. Jirector: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transition.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1										23d. Date of delivery Month Day Year			Year	
ls, P.O.	uires that the signed by Id be detact	þ	23e. Did tobacco use con														
Division of Vital Records,	The law require: cate has been sig page 2 should k	Completed										24a. Was auto perfo	psy ormed?	prio dea	r to con	sy findings npletion of	available cause of
tal	ysician: The is certificate director, pag	Be	25. Was case referred examiner?	Ti-	Hospital:				1		th (Check c		2 6 1	10 / =	100	<i>i</i> /	
Ž	Physic this cral din	2	1 Yes 2 K i	No	1 Inpatier 28a. Date of injury		ER/Outpatier 28b. Time of		Other	4 ∐ Nu		ie 5 🗆 Resi		6 🗷 Other (S	(pecify	11251	zice
o uc	nding ath. :: After e fune	icate	1 X Natural 2 Accident	5 Pending Investigation	(Month, Day,	Year)	injury	M	work?	Yes 2 🗌		ou. Describe i	now mju	ary occurred			
Divisid	al or Atte s after de al Directo ed in by th	Certificate:	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Injury building, etc.	y - At hor (Specify)	me, farm, str	eet, factory,	office		28	Bf. Location (City or Tox		nd Number o. e)	r Rural I	Route Num	ber,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral	Medical	(Check 2	Medical Exami	ician: To the best of m ner: On the basis of exa e Practioner: To the be	amination	and/or invest	tigation, in m	y opinior	n, death oc	curred at the	ne time, date a	and plac	e, and due to	the caus	se(s) and ma	anner stated.
	To the within 2 To the Comple		29b. Signature and titl	e of certifier	Belles	, %	L.D.		License 29	number	5			ate signed (M			1
(JM	1	GREGOR	10 M. B	ELLOSO, M	.D ; 5	302 C		BER	RYD	R., S	ALISE	3UR	Y, M	D :	2180	1
Ī	Stat Registra		31. Date filed (Month, i	Day, Year) N 10 201	32 Registrar'	s Signatu گر	J. pa	ale			7						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3:10 Thelma B. Arold Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A OSP BALTIMORE urity Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov • 21 Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Hours Min. 89 Country) Maryland Director 219-05-5618 Vrs 1921 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Baltimore Arbutus 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1547 Sulphur Spring Road 21227 United States permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items any injury or other traumation. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates White Completed 3 X Widowed 4 □ Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 6 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Frank L. Talbott Mae Collars 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carlene Hannon - POA 1707 Fairview Avenue, Arbutus, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery or enterprise or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State New Cathedral Cemetery 1-26-2011 Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to or as a consequence of): Examiner difficult colit Sequentially list conditions, Examine if any keeling to kinnedi cause. Enter Underlying Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the control of th Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atte in the past 12 months? Dav 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknowh Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy Yes 1 Tes ارگر م /گر Division of Vital 25. Was case referred to medical the funeral director Be 26. Place of Death (Check only one) ٩ 1 🗌 Yes 2 No 1 LInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Suicide 6 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1/ Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Clace JAN 25 2 State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#5perFH, G912, 2/17/2011, WS

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 21 2011 6:05 РМ Molly Bingham Powell Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Golden Living Center Frederick Frederick 231-18-6733 -213-18-6733 If Under 1 Year Age (In vrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** Months Hours Min. (Month, Day, Year) une 26, 1921 Virginia Director 89 June Usual Residence of Decedent fshow Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Virginia Loudon Lovettsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 37805 Clearbrook Lane 20180 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔼No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 X Widowed 4 □ Divorced If Yes, Give Specify: White Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Molly Fern Austin James Edward Powell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37805 Clearbrook Lane Lovettsville, Virginia 20180 Wayne Richard Bingham/son 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 4 Donation 5 Other (Specify) Final Journey Crematory 1/26/2011 Woodbine, Maryland . Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 homes Manita M00957 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ementia Medical Due to (or as a consequence of) Examine Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the attending physician and the for use as the burial-transitions. To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months Month Day Year 5 Other (specify) 1 Yes 2 No 9 Unknown detached ò signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>중</u> Completed 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No ☐ Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Accident Investigation Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, within 24 hours after To the Funeral Direct City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of my knowledge, death vectored at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Frantioner To the basis of my knowledge and the time date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) -24-2011 2 . Name and address of person who completed cause of death (Item 23a) (Type, Print) Tohnson Dr. Frederick MB 21702 65 Thomas 31. Date filed (Month, Day, Year) State 25 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ James F. Burge Jr. Jath. 2019 10:50pm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death
Baltimore Towson Gilchrist Hospice 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 212-42-6855 1 🕱 M 2 🗆 F Months Davs Hours NOW Path, Pat, Year) 943 67 Director MD Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Middle River Baltimore MD 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 Funeral 337 Darkhead Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian. Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sheet Metal Mechanic Vulcan Hart 1yr and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Lucille Smith ပ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en James F. Burge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 337 Darkhead Road Baltimore MD 21220 Joanne Burge /wife 20c. Location - City or Town, State
Baltimore MD 20a. Method of Disposition 20b. Place of Disposition (Name of 1/2^{Date} 2011 1 Burial 2 Cremation 3 Removal from State Bayview Crematory 4 Donation 5 Other (Specify) of Fundinal Service Licen 21. S 22. Name and Address of Facility 300 Mace Ave. Balto. of Essex Connelly Funeral Home 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated experts) Due to (or as a consequence of). the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Other (specify) 4 Pregnant a Pregnant at time of death 1 Yes 2 L 9 Unknown s been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Mes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an his certificate has buildirector, page 2 sh autopsy 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Director: After this in by the funeral dir Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours af To the Funeral Di completed filled in Medical 🗠 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title g 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rom ARATHI KUMAR 31. Date filed (Month, Day, Year)

JAN 2 5 2011 State Registrar

DHMH 17 Rev 7/2009

Registrar

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State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ KURREZ Month Year PM 5.50 Medical 4a. Facility Name (if not institution, give street and number Examiner or Location of Death 4c. County of Death llode cal naure If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛣M 2 🗆 F Hours Min 7 0 Bay Director 220-80-9708 48 Maryland Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director 1 XYes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 2600 Roslyn Ave 21216 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates should be filed within 72 hours aft and Mental Hygiene. Is marked other than "natural", Specify. 3 Widowed 4 Divorced Completed Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade Security Guard Watkins Security Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Department of Health and Ment:
Important: If item 27 is marked
any injury no color. Norman Edward Burrell Phyllis Joan Holsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis J. Holsey(mother) 2600 Roslyn Ave., Baltimore, MD 21216 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Ander Crematory or other place) 01/22/11 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility
QSeph Hullion Ave., Baltimore, MD 21217 21. Signature of Funeral Service Licenses 2140 N. Du rart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or thock, or heart failure. List only one cause on each line. Interval Between Onset and Death Imme The Cause (Final Physician/ Non small COSS una caucer disease or condition 3 week Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death 1 Yes 2 No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a Was an 24b. Were autopsy findings available has autopsy prior to completion of cause of death? certificate 2 No 1 Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Hospital Other: 1 Tyes မှ 1 Inpatient 2 ER/Outpatient 3 DOA Director; After this of in by the funeral dir 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nume Prantioner To the best if my knowledge, death continued at the time, date and place, and due to the 29b. Signature and title of certifier 12011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) baltimore Paul ST. J.NAZARIAN MD 201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 25 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Vonth 8:30 PM 2011 Jan. /Medical Eacility Name (If not institution, 4c. County of Death Examiner Baltimore Nursing atonsville lenter If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) SC 8. Date of Birth (Month, Day, Apr. curity Number rs. last birthday) **Funeral** 3 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Exeminer must be notified at 1 □ Yes 2 **50**lo Director ti more OWYNN 10e. Street and Number 10g. Citizen of What Country? ō items 23a Hvenue 21207 Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 1 1 1 2 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life OO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industr than " Department of Health and Mental Hygiener Important: If item 27 is marked other than any injury or other traumatic event, in Modes. Elementary/Secondary (0-12) College (1-4or 5+) 445 17. Father's Name (First, Middle Be Pages 1 and 2 should be ပ 19b. Mailing Address (Street and Number (Son) 3813 am 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1-2011 4 Donation 5 □Other (Specify) nature of Fundral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atherosderohi **Physician** Cerdiovas cuiar /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to include the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): Box 68760, physician Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No P.0. 5 ☐ Other (specify) detached 9 Unknown 9 Unknown cate has been signed; page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate | Division of Vital 1 ☐ Yes 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 🗌 No the within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mili 21/11 Jammard MD 147683 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SMIPS Kaymond Miller Avenue 2835 Balhoure MD 21209 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 25 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 5:50 P M Month -2011 **1**9 Mildred Childs Hostetter Boynton Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Baltimore 4b. City, Town, or Location of Death Examiner Cockeysville Broadmead Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Days Hours PA reb. 1919 Director 278-12-7861 91 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Cockeysville MD **Baltimore** 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 13801 York Road 21030 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black. White, etc Completed by 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White "natural" 3 X Widowed 4 Divorced or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Helen Shreeve Childs Robert D. Hostetter permit. Page 1 and 2 should be Department of Health and Mer Important; If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 561 Harrington Ave. Concord, MA 01742 Andrew Boynton/son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2X Cremation 3 Removal from State Atlantic Crematory 1/20/11 Glen Burnie, MD 4 Donation 5 Other (Specify) Signature of English ervire licensee 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley 3 23a. Part H. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician. disease or condition resulting in death) Aspiration Medical Examine Sequentially flat conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Completed by Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 1 Yes 2 5 Other (specify) Month Day Year 1 Yes 2 Unknown signed by the Part II. Other significant conditions contributing to 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) 2 🗖 No Other: 잍 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 10:50 PM 5 Pending /utient 2 No 1 Yes Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined ASSISTED LIVING Cochessvill 0 24 hours Medical 29a. Certifier 🗲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Pragitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one 29b. Signature and title of of tifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, JAN 25 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U for State Registral Certificate of Death Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Day 21 VIRGINIA ANUARY 2011 Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4c. County of Death GOOD SAMARITAN 71MORE, MARYLAND If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖫 F (Month, Day, **Director** 216-16-0700 87 Yrs. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be matter at a 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2√ No MD Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 33 E. Timonium Rd. 21093 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Completed 3 Widowed 4 Divorced Specify: white Year or Dates ed other than "natur event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 n/a Bank Manager Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Marie Penn Frederick William Kerr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Bauer/son 4 Steve Way, Baltimore, MD 21236 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place)
ilaney Valley
emorial Gardens 1/26/11 Timonium, MD 21. Signature of Funeral Service 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. Padonia Rd., Timonium, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Examiner NEUMONIA Sequentially list conditions, if any, leading to inneredate cause. Enter Underlying Cause (Disease or iinjury Examine signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Hospital or Attending Physician: The law requires that the death Month Year Pregnant at time of death Day filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 Yes 2 W 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director; After this 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? Natural 5 Pending 2 🗌 No Accident Investigation Suicide Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie

Registrar
DHMH 17 Rev 7/2009

State

completed cause of death (Item 23a) (Type, Print)

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		Decedent's Name	e (First, Middle,	Last)						2. Date of D		110.		3. Time of Death		
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Funeral		5. Social Security N		6. Sex 7	7 Age (In vrs. last hirthday) If Under 1 Year I If Under 2						irth	g. Birth	Birthplace (State or Foreign			
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and show dat	ō	10a. State	10b. County			ty, Town or Lo								10d. Inside City Limits		
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ğ	11. Marital Status 1 ☐ Never Marr 3 ₩ Widowed		12. Was Decede Armed Force 1 ☐ Yes 2 If Yes, Give Year or Date	s? X No		Was Deced f Yes, spec		ispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Ye s or No Rican, etc.))-		ck, White,	ican Indian, , etc. vh ite		
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d 2 shoualth and 27 is n		19a. Informant's Na Elizabeth k				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9107 Simms Avenue Baltimore, Maryland 21234										
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medic	in the past 12 r 1 ☐ Yes 2 ☑ 9 ☐ Unknown	nonths?	1	t at time of	al death 3 L death 5 L	Ectopic p Other (spe				23d. Date of de			Day Year		
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ath. r: After ie funer	icate	27. Manner of Death 1 ☑ Natural 2 ☐ Accident	5 Pending	ation	njury Day, Year)	28b. Time of injury	М 28	lc. Injury work 1 🔲		28d. Describe	how inj	ury occurre	ed			
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Hospita 24 hours Funeral leted filled	Medical Certificate:	(Check 2		Physician: To the best aminer: On the basis of Nurse Practioner: To the	f examination	n and/or invest	igation, in n	y opinio	n, death occurred a	at the time, date	and pla	ce, and due	e to the ca	ause(s) and manner stated.		
To the vithin To the comp.	_ ,	only one) 3 29b. Signature and t		racioner: 101	ne nest of Wi	y kilowiedge, d			e number	ce, and due to t	29d. [Date signed	(Month,	Day, Year)		
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		30. Name and addre	ess of person w	ho completed cause of	f death (Item	23a) (Type, P	rint) K MOR	ARU	MD-2	AKASA 1239	+PU					
State		31. Date filed (Month	n, Day, Year)	32. Red	trar's Signat	lure				, ,						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month January 22, 2011 Milton J. Bull. III 9:30 A. Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Stella Maris Hospice Center Towson Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Funeral Year) 19<u>39</u> 1 🛛 M 2 🗆 F Months Davs Hours Min. OCT. 28 71 Mary land Director 214-36-9983 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Harford Jarrettsville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 3704 Rush Road 21084 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No 1957 Black, White, etc. Completed by 1 Never Married 2 Married 1964 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: White 3 ▼Widowed 4 □ Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Builder Construction Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Milton J. Bull, Jr. Viola May GAtes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Leedy / Niece 2903 Grier Nursery Road Forest Hill, Maryland 21050 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Evans Funeral than el 1 Burial 2 Tremation 3 Removal from State 1/23/2011 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Rel Air 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services—BelAir 21. Signature Funeral Service Licenses 3 Newport Drive Forest Hill MAryland 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate causes. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death Yes Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No icate has been s , page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed this certificate 1 ☐ Yes 2 ☐ No Be (25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Other: ပ္ 1 🗌 Yes 4 □ Nursing Home 5 □ Residence 6 🗷 Other (Specify) HOSICE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending n 24 hours after death.

e Funeral Director: A bleted filled in by the fu Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature a who completed cause of death (Item 23a) (Type, Print) 100 32. Registrar's Registrar

State Registrar

Maryland 21215-0036

Baltimore.

68760

P.0.

Division of Vital

30. Name and address of

Marc I. Leavey, M.D.

31. Date filed (Month, Day, Year) JAN 2 5 20

ompleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

1205 York Road

D-17041

Lutherville, Maryland 21093

2011

anung

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First_Middle_Last) 2. Date of Death 3. Time of Death Physician/ **GEORGE** WILLIAM BOOKHOUT JR Month January 20 3:40P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death OakCrest Village Baltimore Baltimore 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country)
Texas **Funeral** 1 XX^M 2 □ F Months Days Hours Director Vrs 11/01/1920 456-44-3999 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Tes 2 XXNo Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8800 Walther Blvd 21234 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

KXYes 2 No WIII Black, White, etc. ģ 1 Never Married XX Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XX No Specify. Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Executive Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 George William Bookhout Sr Louise Goodloe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marjorie Watson Bookhout DTR 225 Gaywood Road Baltimore, Maryland 21212 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2XXCremation 3 ☐ Removal from State Ardent Cremation Inc 01/24/2011 ☐ Donation 5 ☐ Other (Specify) Hanover, Maryland 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or compl shock, or heart failure. List only on tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final schemic Cardcomyopath onysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events attending physician and for use as the burial-trar Due to (or as a consequence of). resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Faclure, CAD Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an . Were autopsy findings available prior to completion of cause of Hospital or Attending Physician: The law 24 hours after death. Funeral Director: After this certificate has page 2 autopsy death? 1 Yes 2 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ဂ္ Other 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 2 🗌 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1/20/2011 R171944 CRAP MIN 30. Name and address of person who leted cause of death (Item 23a) (Type, Print) MICHOURS
31. Date filed (Month, Day, Year)
IAN 25 GHORROR Michaelle 8800 walther Blvd, Parkville MD 21234 State

DHMH 17 Rev 7/2009

Registrar

Bookhout

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 20:22 PM MAL 23 2011 /Medical 4a. Facility Name (If not Institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner St AGNES HOSPITAL RALTIMORE 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□ F Months Days Hours 213-32-4288 Director Usual Residence of Decedent 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 □ No Funeral Director 10 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Exeminant manual in-Luzeine -120-5 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) 2 \(\text{No} \) Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: Completed by Specify: £ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life_DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HO 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and Balto, md. Son orie Willia 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1⊠Burial 2 ☐ Cremation 3 ☐ Removal from State -29-2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ancy m. Wallace F.S 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause Final Metastatic Physician lung cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (bras a nonsequence of) been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by strointestinal 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an this certificate has autopsy 2 DNo 1 □ Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M.D P23748 Jan, 23,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21229 RAJANI JAGANA, 900 SOUTH CATON AVENUE, BALTIMORE, MD 31. Date filed (Month, Day, Year)

JAN 25 2011 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 135AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner OWSON If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛣M 2 🗆 F Months Days Hours Min. (Month, Day, **Director** 219-07-9196 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD. Towson Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21204 615 Chestnut Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces' Black, White, etc. 1 Never Married 2 Married þ 2 No XYes Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give White Completed 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland Transit Worker marked other æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Smiley Daisey Wilbur Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>s</u> and 2 s Health 4 Southwark Bridge Way Lutherville, MD. 21093 Valerie Brown/ Daughter in Law permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other t or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Co. 1-26-11 Towson, MD. Signature of Funeral 8 22. Name and Address of Facility on Funeral Home, Inc. 1050 York Rd. Towson, 23a. Part 1. Enter the disease/or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ emen disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine il any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown icate has been sig 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy After this certificate Division of Vital 25. Was case referred to fiedical Be 26. Place of Death (Check only one) examiner? 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending I hin 24 hours after death. the Funeral Director: After Natural injury work? 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) me and address of person who completed cause of death (Item 23a) (Type, Print) MO Ba 140. 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 201^{Year} Patricia Ann Becker 5:00 Ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Baltimore Towson Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Months Min Days Hours (Month, Pay, West Virginia **Director** 215-28-3770 82 June Usual Residence of Decedent show 10a. State 10b. County notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f MD 1 Yes 2 No Baltimore Towson ō 10e. Street and Numbe 10f. Zip Code "natural", or items 23a or 10g. Citizen of What Country? Funeral with 1 28 Dunvale Road 21204 Apt. A-T USA and 2 should be filed within 72 hours after death Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ģ 1 Never Married 2 X Married Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: white I Hygiene. other than "nature ent, the Medical E Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygien Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph T. Sinnott Wilda V. Bishop 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau William H. Becker husband 28 Dunvale Road Apt. A-T; Towson, MD 21204 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 1/24/2011 4 Donation 5 Other (Specify) Baltimore, MD 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home. Inc. Towson, MD 21204 23a. Part 1. Enter the disease, or complicati shock, or heart failure. List only one ca that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Retween Immediate Cause (Final Onset and Death Physician/ disease or condition estive ona Medical resulting in death) Medical Examiner Due to (or a sonsequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Union or lists Examiner Due to (or as a consequence of). or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or linjury that initiated events and resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy Pregnant at time of death Month be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 💆 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has, page 2 HIO Colon performed? Yes 2 No this certificate 1 Yes 2 No 25. Was case referred to medical B 26. Place of Death (Check only one) examiner? Hospital 2 X No Certificate: To 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA Detrent 4 Nursing Home 5 Residence 6X Other (Specify) funeral 27. Manner of Death 28c. Injury at work? 28a. Date of injury (Month, Day, Year) 28b. Time of After 28d. Describe how injury occurred 1 Natural 5 \square Pending injury nours after death.

neral Director: Aft
filled in by the fur 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours ar Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number V. Comp K125808 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Don 4100 a N. 32. Registrar Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 2011 21, January 1:25 Gertrude Chapman АМ Durrer Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Rockville Casey House Montgomery 6. Sex Age (In vrs. last birthday) Inder 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Days Hours Min Washington, DC Director 577-16-1969 91 1919 Usual Residence of Decedent show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 Yes 2 No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4704 Western Avenue 20816 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify "natural", Specify: 3 - Widowed 4 Divorced White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. tem 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Secretary Legal Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Jesse J. Durrer Lou Ella Wash Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Linda S. Wensley/daughter 7137 Bradshaw Court East Frederick, Maryland 21703 item 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 Department of Important; If it any injury or o ō 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Final Journey Crematory 1/24/2011 Woodbine, Maryland 21. Signs are of Funeral Service Licen Going Homes Cremation Service P.O. Box 784 anda Homas M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 🕽 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Cerebral Artery Occlusion Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate caces. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo 4 Pregnant Pregnant at time of death 5 Other (specify) Month Dav Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Cerebral Infarction 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No Yes 2X No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 XNo Other: 잍 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Certificate: 28c. Injury at work? injury 5 Pending Accident Investigation 1 Yes 2 No Director; 6 Could not be Suicide ithin 24 hours after de the Funeral Directo impleted filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the I

completed only one 29b. Signatyre and ti#e 29c. License numbe 29d. Date signed (Month. Day, Year) R143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Debrah Miller, CRNP 6001 Muncaster Mill Road Rockville, Maryland 20855

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

JAN 25 2011

32. Registrar's Signatur

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** 2011 DONNE ANUARY 21, 201 /Medical 4a. Facility Name (If not institution, give street and number) Examiner The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours XIM 2 DE 411-23-8245 Yrs Director 04-16-64 TN 46 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits aţ 1 X Yes 2 No Director MD NABaltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? #1707 er than "natural", or items 23a or the Medical Examiner must be Fayette Street Apt. 21201 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. African 11. Marital Status 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify þ Specify: American 3 ☐ Widowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Grade Wachovia Bank Assistant Analysis 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Chambers Harry Sadie Robinson 19a. Informant's Name/Relationship (Type. Print) Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 is other tra Sadie Robinson-Chambers 1318 Railton Road Memphis, TN 38111 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 nent of P int; If ite 1 🗌 Burial 2 💢 Cremation 3 🗌 Removal from State permit. Page Department o Important; If a Metro Crematory 01-25-11 Catonsville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenset 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a chisequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Liscase or that initiated events the burial-trai resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death Live birth 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 2 No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 XNo certificate or Attending Physician; completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \sum Nursing Home 2 No 1 Yes 1X Inpatient 2 ER/Outpatient 3 DOA 6 ☐ Other (Specify) မ 5 Residence 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death.

To the Funeral Director: After 1 Natural 2 Accident 5 Pending investigation Injury 1 🗌 Yes 2 □ No 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital Sucertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 Jessica Naugen-120ng Day, Year 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ COOK MANCY Month 11156 AM JAN Medical 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SINAI HOSPITAL OF BALTIMORE BALTIMORE CITY 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F Hours 218-40-1976 Country) Director 68 Nov. 18, 1942 MD Usual Residence of Decedent 28a-f shov 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Middle River 1 Tes 2 No 10e. Street and Number ŏ 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 428 Kosoak Road 21220 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. "natural", or 1 Yes 2 No If Yes, Give Year or Dates. δ 1 Never Married 2 Married Maryland 21215-0036 72 hours after 1 ☐ Yes 2 🔀 No Specify: Specify:White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, the Megones, once. Elementary/Seconday (0-12) College (1-4 or 5+) Costco Stocker 7th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James A. Little Margaret Bauers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David J.R. Cooke /son 428 Kosoak Road Middle River MD 21220 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Bayview Crematory 1/21/11 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun ral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility 300 Connelly Funeral Mace Man 23a. Part 1. Enter the disease, or co shock, or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ASYSTOLE disease or condition Medical resulting in death) Examiner DAYS SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the bunal-transit completed filled in by the funeral director, page 2 should be detached for use as the bunal-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months? Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ISCHEMIC COLITIS ABDOMINAL 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? FISTULAS 24a. Was an MYDCARDIAL IMFARCTION 1 ☐ Yes 2 No 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural work?
1 Yes 2 No 5 Pending 2 Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier JAN 20 4011 000 RES 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PANDEY, MD MOSPITAL OF BALTIMORE SINAL 31. Date filed (Month, Day, Year)
JAN 25 2011 32. Registrar's Signature State Registrar

11-00629 Russell Dean Caster

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible $_{O}$ \cap $ \cdot $ $ \cdot $	011.0
State of Maryland / Department of Health and Mental Hygiene	J . + U

	1- For State Registrar	Cer	tificate of	Death		Reg.	. No.	
Physician/	Decedent's Name (First, Middle,Last	•				Date of Death Month Death	Day Year	3. Time of Death
Medical Examine	Russell D. 4a. Facility Name (if not institution, given			b. City, Town, or L	ocation of Death	Month January 23,	2011 4c. County of [1020 hrs
.)	925 Renfrew Street			Essex			Baltimore	County
Funeral Director	5. Social Security Number 6. S 191-54-0727	ex	ast birthday) Yrs.	If Under 1 Year Months Days	if Under 24Hrs. Hours Min.	June 28	F	9. Birthplace (State or foreign PA
wu w	Usual Residence of Decedent 10a. State 10b. County	10c City	Town or Location	en .				10d. Inside City Limits
A	MD Balti		Essex					1 Yes 2 No
The Maryland as or 28a-f shu officed at once		Street		10f. Zip Code 2 1 2	221	109	. Citizen of What USA	Country?
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be positified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married	1 X Yes 2 No	If Ye	Decedent of Hisp s, specify Cuban,	Mexican, Puerto		White, e	
s after rail, prince	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		Yes 2 No s Usual Occupation	La La College	ork dono	Specify: W.	C. C C. C. C. C. C. C. C. C. C. C. C. C. C.
OO36 within 72 hour giene. Medical Examom Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during mo	st of working life. [k Drive	DO NOT use retir	ed)		ll IND.
5-0036 iled within 7 Hygiene. I other than the Medical	12th 17. Father's Name (First, Middle, Last					(First, Middle, Ma	iden Surname)	
215- be filed and Hyg rked off	Thomas G. C			"		rine R.		
should the mark of	19a. Informant's Name/Relationship (Гуре, Print)			and Number or R	ural Route Numbe	er, City or Town,	
and 2 s ealth a seem 27 traum	Diane L. Cast			Renirew ion (Name of ceme		t Balti	more Mi	
MOFe, Pages 1 a tent of He tent of He tent of Me	1 Burial 2 Cremation 3	Ray	rematory or other	erplace) Cremato	ry 1/:	29/2011	Balti	more M ^D
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical To Be Comple	21. innature of Funeral Service Licer			me and Address o	301	Mace	Ave. Ba	alto. MD
Physician	232 Part I. Enter the disease, or comp				runer	ar Home	of Es	Sex 21221 Approximate Interval
/Medical	failure. List only one cause on ea Immediate Cause (Final disease a.	ach line. Hypertensive	Atheros	clerotic	Cardiov	ascular	Disease	Between Onset and Death
LAGIIIIIGI	or condition resulting in death)	Due to (or as a consequence of)					± 404 mac and electron	
ted Insit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequence of)						
ecuted and - transit	events resulting in death) Last	Due to (or as a consequence of)):					
e ia ia i	X UNPENDED	AMENDED 23a,27 p		g912 2-25	5-11 vt			
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna	2 Feta		Ectopic pregnar	ісу	23d. Date of del Month	livery Day Year
b. Box 687 the death certification by the attending sched for use as t	1 Yes 2 No 9 Unknowr	Pregnant at time of dea Unknown	5 Othe	er (Specify)				
P.O. that the ned by the detache	Part II. Other significant conditions	contributing to death but not res	sulting in the un	derlying cause giv	en in Part I.			e to the cause of death?
ords, P.O. v requires that the s been signed by should be detach			· · · · · · · · ·			1 Yes		Probably 4 Unknown e autopsy findings available
Records, The law require ficate has been sig		-				autopsy performe	prior ed? deat	to completion of cause of th?
tal Rec	25. Was case referred to medical			26 Place o	f Death (Check o	1 Yes 2	No 1 ✓	Yes 2 No
Physician: Physician: Print certif ral director, To Be (avaminos?	Hospital: 1 Inpatient 2 E	ER/Outpatient		thor —		esidence 6 🗸	Other: Scene
Division of Vital Records, P.O tal or Attending Physician: The law requires that is after death. **I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacertification: To Be Completed by F	27. Manner of Death 1 X Natural 5 Pending	(Month, Day,Year)	28b. Time of Inj	· I — ·	at Work?	28d. Describe hov	v injury occurred	
Division or ospital or Attending hours after death. Inneral Director: After y filled in by the function: Certification:	2 Accident Investigati 3 Suicide 6 Could not determine	be 28e. Place of Injury - At hor	me, farm, street	factory, office bui	Iding, etc.	28f. Location (Stre or Town, State		r Rural Route Number, City
the Ho hin 24 j the Fu npletely	29a. Certifier 1 Certifying Physic	ian: To the best of my knowledger:On the basis of examination and						
To with	29b. Signature and title of certifier	and manner stated.		29c. License	number	2	9d. Date signed	(Month, Day, Year)
	Theodon Il	King Je	u.D	O.C.M	.E. 00	VIE J	January 24, 2	011
	30. Name and address of person who Theodore M. King, Jr., MD		•	00 W. Baltimo	ore Street, Ba	Itimore, MD 2	21223	
State	31. Date filed (Month, Day, Year)	32. Registrar's Signature	е					
Registrar	JAN 25 2011	more p. for	arke	<u>.</u>				
DHMH 17 Rev 1/2001 OCME 2006			ORIGINAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ B. Chambers Month Day Year Leonard 6:47PM Tanuary Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral 1 M 2 □ F **Director** Usual Residence of Decedent 10c. City, Town or Location show 10b. County 10a. State with the Maryland notified at Director 10d. Inside City Limits 28a-f 1 Yes 2 No timome 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? must be Funeral Stanwood 21206 items 23a USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, other traumatic event, the Medical Examiner Armed Forces?

Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ö þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No "natural" 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, and Mental F ၉ Permit. Page 1 and 2 st.
Department of Health an.
Important: If item 27 is m
any injury or other 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21206 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of bisposition Date Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyind, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ End-Stage Liver Disease disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate

Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 🗌 No Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) 2 🖪 No Hospital: Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 Tes 2 No M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 75 Rajapahse M.D 00057465 1/21/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balhmore, MD. 2120 2835 Smith M. 5-203. N-S. Rajapakse, miD 31. Date filed (Month, Day, Year) JAN 25 2011 32. Registrar's Signature State Registrar

A DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Thomas Francis Clement January 21, 2011 1:45P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 707 Maiden Choice Lane Apt. 9108 Catonsville Baltimore 7. Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1**XX**M 2 □ F Months Days Hours Februt 264 1928 Director MD 220-20-4303 Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD Baltimore Catonsville 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Completed by Funeral items 23a 707 Maiden Choice Lane 21228 Apt. 9108 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc.

White Armed Forces?
1 Yes 2 No 1 Never Married 2 xx arried P 1 XXes 1 Yes 2 No Specify: "natural", Specify: Year or Dates 1951-54 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 6 Dentist Private Practice Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Hugh Melvin Clement, Sr. Emma M. Smith injury or other traumatic permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 707 Maiden Choice Lane, Apt. 9108 Catonsyille, MD Mrs. Esther R. Clement Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Dulaney Valley Memorial 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/29/11 Timonium, Maryland 4 Donation 5 Other (Specify) 22 Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc.
10 W. Padonia Road Timonium, Maryland 21093 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a, Part 1. Enter the dis Interval Between nset and Death Immediate Cause (Final Ph_sician/ oton anco disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of, attending physician and I for use as the burial-transit Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Parleinson's 1 Yes 2 No 3 Probably 4 Unknown Completed plnous been s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has le 2 autopsy perform death? certificate Yes Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Tes 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 28a. Date of injury (Month, Day, Year) Manper of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural 1 🗌 Yes 2 🖵 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 after death.

Director: After to in by the funera within 24 hours after To the Funeral Direct completed filled in b

be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

State Registrar only one

Michael

29b. Signature and title of certifier

10

31. Date filed (Month, Day, Year, 32. Registrar's Signature IAN 25

MO

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ro

Maiden C

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21228

Catoniville

holce LN.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 Theresa Marie Cook 10:45P M Medical <u>January</u> 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death <u>Seasons Hospice @ Northwest</u> Hospital Randallstown Baltimore 5PM 8. Date of Birth (Month, Day, Year) Feb 1. 1920 Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 90 **Director** Yrs **193-16-5030** Pennsvlvania Usual Residence of Decedent 72 10a. State 10b. County hours after death with the Maryland 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits 28a-f 1 ☐ Yes 2🏋 No Maryland Gwynn Oak <u>Baltimore</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21207 6800 Richardson Road USA 0 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. Ь 1 Never Married 2 Married δ If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: White "natural" Completed 3 Widowed 4 Divorced Specify 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 5 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. 2121 S within 7 Elementary/Seconday (0-12) College (1-4 or 5+) Clerk 10 Federal Government Be Maryland 17. Father's Name (First, Middle, Last) COOK 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F permit. Page 1 and 2 should be.
Department of Health and Mental Important: If item 27 is many injury or other. မ Antionette Rigliano Giovanni Marnelli 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) eresa 6800 Richardson Road Gwynn Oak, Maryland 21207 <u>Mark Cook, Son</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/27/11 Woodlawn Cemetery Woodlawn, Maryland Funeral Service Licensee Thomas Gregor MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ 6 ema toma disease or condition mal Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has b director, page 2 sl autopsy death? 2 XNo 1 🗌 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 X Yes 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specify) HOS PICE Certificate: To 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of injury (Month, Day, Year) 2007 Doy kw.KwowW 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred ☐ Natural 5 Pending n 24 hours after death.

Funeral Director: Af bleted filled in by the fu 1 Yes Accident 2 No un Knowk Investigation 6 Could not be Suicide
Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Bural Route Number, City or Town, State) & 800 Michard Son Balt, mere, Md 212 determined Home , Md 21207 Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 30. Name and address of person completed cause of death (Item 23a) (Type, Print) State Registrar

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Wayne Channing		offy 1- For State	State o	f Maryland / D	epartment o Certificate o			ental H	ygiene				
Physicia		Registrar							Reg. No. 2. Date of Death Month 2. Date of Death 3. Time of Death			of Death	
Medical Examir	ıer	Wayne				Month January				1 hrs			
)		4a. Facility Name (if not insti Prince George's H		street and number)	l l		own, or Locati erly, MD	on of Death			c. County of D Prince Geo		
Funeral		5. Social Security Number	6. Sex	7. Age (In	yrs. last birthday)			Inder 24Hrs	_	Birth(MM	/DD/YYYY) 9.	. Birthplace (State or
Director		213-45-3888	1 N	1 2 F	5 Yrr	Month:	s Days H	ours Min.	06/1	0/19	15	Country)	MD
Au au à	F	Usual Residence of Deceder 10a. State 10b. Cou		10c.	City, Town or Loca	tion						10d. Ins	side City Limits
B .11	٦	MNP	rince	Cocorge	Landone	-						1 🗆	Yes 2 No
Maryland 28a-f show	Director	10e, Street and Number		<u> </u>		10f. Zip	Code			10g. Cit	tizen of What (Country?	
ith the 23a or		11. Marital Status	chord	Summi- 12. Was Decedent Ever	+ C+.	2 Decede	078	S Origin2 (Sr	acify Vas or	No	14. Race - A	merican India	an Black
r death with the Maryland or items 23a or 28a-f sho must be notified at once	Funeral	1 Never Married 2	Married	Armed Forces?			Cuban, Mexi			140-	White, et		II, Diaot,
ral", o	DY F	3 Widowed 4	0	Yes, Give Year or Dates:	1		4 No spe	•			Specify: B	ack_	_
2 hours		15. Decedent's Education (Elementary/Secondary (0-		highest grade complete College (1-4 or 5+)			occupation (G king life, DO N			16b.	Kind of Busine	ss/industry	
5-0036 led within 7: Hygiene.	Completed	gth		, ,			Stu	den	+				
D 21215-00; should be filed with and Mental Hygiene 7 is marked other the natic event, the Men		17 Father's Name (First, Mid	dle, Last)	` .			18.Mo	ther's Name	(First, Middle	e, Maiden	Surname)		
2121 Muld be fi Mental marked e event,	To Be	19a. Informant's Name/Relat	onship (Typ	e, rint)	19b. Mailin	g Address	(Street and	Number or F	Rural Route N	lumber, C	City or Town, S	tate, Zip Cod	
MD d 2 sho lith and n 27 is		Gertrude	G.	Duncan	121	02 (richa	rd S	ummi	+ C	イラグ	00 yes	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-fah injury or other traumatie event, the Medical Examiner must be notified at once		20a. Method of Disposition 1 Burial 2 Crema	ition 3	Removal from State	20b. Place of Dispos crematory or of		e of cemetery		Date	300.	Location - City	y or Town, St 9 Rd	ate
	-	4 Donation 5 Othe	: Specify:		T. Lince		Address of Fa	ility	4-201	115	Brentw	cod, L	10
Balti permit. Departn Import		10441	MAA	en		10,500	Fun	erd S	Seculia	م برد	18 1ce	Sh	C20011
Physician	\exists	23a. Part I. Enter the disease failurg. List only one ca			death. Do not enter t	he mode o	f dying, such e	es cardiac o	r respiratory a	arrest, sh	ock, or heart		ximate Interval een Onset and
ixaminer	İ	Immediate Causa (Final dise or condition resulting in deat	_	ead Injuries le to (or as e consequer	non of):							-	Death
		Sequentially list conditions,	b	e to (or as a corrisador	nce or).								
	<u> </u>	if any, leading to immediate cause. Enter Underlying Ca	use	e to (or as a consequer	nce of):								
sit d	Examiner	(Disease or injury that initiate events resulting in death) La		e to (or as a consequer	nce of):								
ecul	dical	UNPENDED	d	AMENDED								+	
- a 5 5	Φ ⊢	IF FEMALE:		23c. If yes, outcome of	pregnancy					23	d. Date of deli	very	
lox 68760 eath certificate be attending physi for use as the bu	sician/M	23b. Was decedent pregnant past 12 months?	- 1	1 Live birth 4 Pregnant at time	-6 -1	tal death		opic pregna	ncy		Month	Day	Year
Box 6876. The death certificate the attending phy leed for use as the t	hysic	1 Yes 2 No 9		9 Unknown	2 0	her (Spec	my)						
that the	a a	Part II. Other significant co	nditions co	ontributing to death but	not resulting in the	underlying	cause given ir	Part I.			use contribute No 3 F		
Division of Vital Records, P.O tal or Attending Physician: The law requires that the rather death. **I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted.	eted								24a. Wa				dings available
COFC to law re to has be	Comple								per	opsy formed?	death	1?	n of cause of
tal Rec	ပ္ပါ	25. Was case referred to me	dical			2	6.Place of De	ath (Check o		2N	lo 1 🗸	Yes	2 No
Vita	<u>8</u>	examiner? 1 Yes 2 No	Hos		2 🖊 ER/Outpatient						ence 6 O	ther:	
n of ding Ph.h. After t		27. Manner of Death 1 Natural 5	ending	28a. Date of Injury (Month, Day, Year) Jan 18, 2011	28b. Time of I 1855 hrs	njury 2	8c. Injury at W 1 Yes 2	!	28d. Describ Pedestriar				
VISIOF or Attend filter death Director: in by the	<u>licati</u>	2 🗹 Accident	nvestigation could not be	28e. Place of Injury -	At home, farm, stre	et, factory,		-			and Number or	Rural Route	Number, City
Divisior Hospital or Attend 24 hours after death Funeral Directors etely filled in by the	Certification:	4 Homicide	etermined	(Specify) Major F	Road / Highway			ı	or Town Landover D	, State) odge Pa	ark Rd, Land	over, MD	
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physompletely filled in by the funeral director, page 2 should be detached for use as the b	ज़	29a. Certifier 1 Certifyin (Check only 2 Medical	Examiner: 0	: To the best of my kno n the basis of examinat	wledge, death occur ion and/or investiga	red at the tion, in my	time, date and opinion, death	place, and occurred a	due to the ca t the time, da	use(s) ar te and pla	nd manner as s ace, and due to	stated. o the cause(s	s)
To COT	ĕ	29b. Signature and title of ce		nd manner stated.		29c.	License num	per		29d.	Date signed (Month, Day,	Year)
		Une 12			_		O.C.M.E.			Jan	uary 19, 20)11	
(2)		30. Name and address of per Ana Rubio MD.		npleted cause of death Medical Examine	,	imore S	treet, Baltir	more, MD	21223				
		31. Date filed (Month, Day, Ye	ar)	32. Registrar's Si	gnature								
Registr	eπ	AUII MA CALL	plene	was po. to	Puru								

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 21, Day 2011 3:50 A. Physician/ Ruth E Daiker Medical 4a. Facility Name (if not institution, give street and number) County of Death Baltimore 4b. City, Town, or Location of Death Examiner Towson Gilchrist Hospice 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign Funeral Month, Day Days Hours Mary land 1 □ M 2 🖺 F 74 219-32-3507 Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State with the Maryland Director Maryland 1 4 1 Baltimore 3 8 1 Parkville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Countr 0 "natural", or items 23a o USÁ Funeral 21234 9941 Harford Road within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black White etc. Completed by 1 Never Married 2xx Married 1 ☐ Yes 2 🕱 No If Yes, Give Maryland 21215-0036 White 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates Medical 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) Baltimore Community Resource Center permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Director of Substance Abuse Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Doris Smith ဂ္ဂ Arthur Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 1813 Fairview Avenue, Halethorpe, Maryland 21227 Daughter Robin Woodell Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Atlantic Crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1/23/2011 Glen Burnie, Maryland 21. Signature of Juneral Service Licens 2. Name and Address of Facility Burgee Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 21211 23a. Part 1. Enger the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or deart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final vanacatic Physician Cancer nowths disease or condition resulting in death) Medical e to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) physician and the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical law requires that the death certificate be P.O. Box 68760 as 1 IF FEMALE: nse (23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year for Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 🛱 Probably 4 ☐ Unknown Records, been 24b. Were autopsy findings available 24a. Was an his certificate has b I director, page 2 sf prior to completion of cause of death? perform Yes 2 the Hospital or Attending Physician: The Ithin 24 hours after death.

the Funeral Director: After this certificate himpleted filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA မှ 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the F

complet 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 2/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6201 N. Charles ST TOWSOW

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jan. Physician/ 201°1 10:40 A M Hester Alverta DeHaven Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Baltimore Towson Gilchrist Birthplace (State or Foreign Country)
 MD Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2X F Sept. 10,1910 Months MD 219-05-1758 100 Director Usual Residence of Deceden ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 8800 Walther Blvd. #3412 21234 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3XXWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) during most of working 1 and 2 should be filed within 7: of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lula Mae Price Albert Irvin Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Pinewall Place Nottingham, MD 21236 Melanie Hynson/Daughter permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 1/24/11 Upperco, Maryland Forest Ridge Cemetery 21. Signature of Funeral ²² Name and Address of Facility Home of Dulaney Valley, Inc. Michael' 10 West Padonia Road Timonium, Maryland the disease, or c ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a, Part Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition Pnysician Debeleti Medical resulting in death) Due to (or as a consequence of): Examiner occurd Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last ling physician and e as the burial-trans Due to (or as a consequence of): Physician/Medical that the death certificate be attending IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 No fo Pregnant at time of death led by the a detached f Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 9 Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 Yes 2 No Yes 2 Division of Vital or Attending Physician: 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **X**No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury 1 🔀 Natural 5 Pending 1 Yes 2 No M 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) R125808 all some

Registrar

State

Print) Anne (cus 4105 Beltimos

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? State
Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12:52 A M Desiree De Rosa January Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country 1 🗆 M 2 🌋 F Months Days Hours Min. Feb 16 **Director** 220-84-2976 44 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🙀 No Maryland Montgomery Montgomery Village 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10555 Cambridge Court 20886 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🔀 No Specify. 3 Widowed 4 X Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 11 <u>Medical Assistant</u> Doctor's Office Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Richard Harry Armentrout, Sr. Mary Lynn Ouigley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Lynn Armentrout/mother 10555 Cambridge Court Montgomery Village, MD 20886 permit. Page 1 and 2 Department of Healt! Important: If item 2 any injury or other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 1/24/2011 Woodbine, Maryland 21. Sign to e of Funeral Service Going Home Cremation Service P.O. Box 784 Ramos uanita M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Pard. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Liver Cirrhosis Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of) ending physician and use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 【XNo Pregnant at time of death 5 Other (specify) Month Day Year 4 Pregnant 1 ☐ Yes ∠ ☐ 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by þ Records, Hepatic Encephalopathy 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Acute Kidney Failure page 2 s autopsy performed 2 No Yes 2 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 10 Other: 4 \square Nursing Home 5 \square Residence 6 \bowtie Other (Specify) 1 🗌 Yes 2 **X**No 1 Inpatient 2 ER/Outpatient 3 I DOA Hospice funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending work Accident
Suicide 1 Tes 2 🗌 No 24 hours after death Funeral Director; A Investigation 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined filled in t Medical 29a. Certifier **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) D37142 ess of person who completed cause of death (Item 23a) (Type, Print) 1355 Piccard Drive Coleman M.De Rockville, Maryland 20850 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 201 1 Thomas Ewart Drummond January 2:21 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Casey House Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day Year)
June 25, 1939 Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Country) Ohio 1 🛣M 2 🗆 F Hours Director 579-50-7403 71 June Usual Residence of Decedent show should be filed within 72 hours after death with the Maryland 1 and Mental Hyglene. 7 is marked other than "natural", or items 23a or 28a-f show ms 23a or 28a-f sho must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2 No Montgomery Potomac 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 9 Trailridge Court 20854 United States "natural", or items edical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 X Married 9 Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates. 1964-66 Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+ the Dentist Dentistry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Folsom Ewart Drummond Arlene Reed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sh nt of Health a : If item 27 is Joan M. Drummond/wife Trailridge Court Potomac, Maryland 20854 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 \square Burial 2 \boxtimes Cremation 3 \square Removal from State injury or permit. Page Department Important: It any injury or 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 1/25/2011 Woodbine, Maryland . Signature of Funeral Service Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD Homos M00957 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic Prostate Cancer disease or condition vears Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exam that initiated events Due to (or as a consequence of) resulting in death) Last burialphysician Physician/Medical certificate be Box 68760 the as attending plant for use as JE FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months' 1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 No Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 this certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: $_4$ \square Nursing Home 5 \square Residence 6 \bowtie Other (Specify) \bowtie HOSPICE 2X No. ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work' 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 [Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D37142 January 22, 2011 20+1 30. Name and address of person who completed cause of death (Item 23a) Type, Print) Coleman, M.D. 1355 Piccard Drive Rockville, Maryland 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 25 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day George E. Dail January 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice Center Baltimore Towson 8. Date of Birth 9. Birthplace (St. (Month, Day, Year))
Apr. 25, 1930 Virginia If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 XM 2 🗆 Hours 80 Director 227-26-1555 Apr. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Director ms 23a or 28a-f s must be notified 1 ☐ Yes ※XX No Harford Maryland Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 327 Dennison Way 21001 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status "natural", or ite Black, White, etc. Armed Forces? 1946 þ 1 Never Married 2 Married 1 X Yes 2 No land 21215-0036 1952 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 XWidowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Businessman Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Earl Dail Ethel Fanney Baltimore, Maryl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adrienne Earnshaw / Daughter 908 Country Club Road Havre de Grace MD 21078 Department of Health Important: If item 27 any injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of Evans Funeral CHapel Bel Air 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/24/2011 Forest Hill, Maryland 22. Name and Address of Facility Evans Funeral Chapel & Cremation Service—BelAir 21. Signatur Funeral Service Licensee Da Newport Drive Forest Hill, Maryland 21050 tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Special 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Scertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

State Registrar VALLEY RD TIMONIUM

person who completed cause of death (Item 23a) (Type, Print)

2300

Day 5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Doris Ella Dixon Physician/ 2011 11:45 PM January Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore 2402 Harwood Road Parkville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 16, 1916 Social Security Number 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 213-30-9661 1 □ M 2 🗶 F 94 Baltimore, Director Usual Residence of Decedent 28a-f shov 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director "natural", or items 23a or 28a-f sl edical Examiner must be notified Baltimore Parkville MD 1 Yes 2X No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 2402 Harwood Road 21234 United States Page 1 and 2 should be filed within 72 hours after deathment of Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. by 1 Never Married 2 Married Yes land 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White Completed 3 X Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Morgan Millard Elementary/Seconday (0-12) College (1-4 or 5+) Waitress 11 and Mental Hygier is marked other 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edward Leyhe Marie Zajic Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 69 Crystal Court, Bel Air, MD 21014 Melvin Dixon, Jr./ Son fimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State January Gardens of Faith 4 ☐ Donation 5 ☐ Other (Specify) Rosedale, Maryland Cemetery 25, 2011 Signature of Funeral Service Licensee 22 Name and Address of Facility hapel & Cremation Services 8800 Harford Rd. Parkville, Maryland 21234 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death Physician/ Medical resulting in death) a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Examine attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No signed by the atte 5 Other (specify) Month Day Year Pregnant at time of death g Unknown 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been si irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 No 1 🔲 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 No 2 Accident after death the f Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be n 24 hours after de e Funeral Directo pleted filled in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JAN 25

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Antonio

within 2 To the F

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

022408

2205 york Rd. Suite 101.

29d. Date signed (Month. Day, Year)

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amela D. Dixon		or State (Certificate of I		ientai i iy		2011	7
Physician		strar ecedent's Name (First, Middle,Last)			- 12	Reg. 2. Date of Death		3. Time of Death
ledical Examine		PANTOLA DI DIXON				Month D January 21,		1603 hrs
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	-	St. Agnes Hospital ocial Security Number 6. Sex 7. Age (In y	rrs. last birthday)		Under 24Hrs.	8 Date of Birth/	MM/DD/YYYY) 9. Bir	tholace (State or
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ath wi	あ し	Marital Status 12. Was Decedent Ever Never Married 2 Married Armed Forces?	If Yes	Decedent of Hispanions, specify Cuban, Mex			White, etc.	/
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ansit		onts resulting in death) Last Due to (or as a consequent d.	ice or):					
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Box 68760, c death certificate be exe the attending physician 2 of for use as the burial -		EMALE: 23c. If yes, outcome of					23d. Date of deliver	
687 certific nding se as t	230	Was decedent pregnant in the past 12 months?	of dooth		ctopic pregnan	су	Month [Day Year
Box e death the atter	10	Yes 2 No 9 ✔ Unknown g Unknown	5 Otne	er (Specify)				
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Division of Vital Records, tal or Attending Physician: The law requir is after death. al Director: After this certificate has been seled in by the funeral director, page 2 should list.	<u> </u>					1 Yes 2		es 2 No
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Divis		Suicide 6 Could not be determined (Specify)				or Town, Stat	e)	
		Certifier 1 Certifying Physician: To the best of my known control of the best of the best	wledge, death occurre	ed at the time, date ar	nd place, and o	fue to the cause(s	s) and manner as stat	ed.
To the Ho within 24 To the Fu completely	Nedical (Ca	and manner stated.	ion and/or investigation	29c. License nur			9d. Date signed (Mo	
	29	Signature and title of certifier		O.C.M.E			January 23, 201	
	30	Name and address of person who impleted cause of death	(Item 23a)				,,	
Ø J		Russell Alexander MD. Assistant Medical E		V. Baltimore Stre	eet, Baltim	ore, MD 2122	3	
Sta	te ³¹	Date filed (Month, Day, Year) 32. Registrar's Signature 32. Registrar'	gnature		-			
Registra	ar	JAN ZO ZUI LENUN	13. MIGH	-				

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year SARA 1110 PM F. Diton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore County Glen Arm Glen Meadows Retirement Community 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days 1 □ M 2 🗶 Jan. 17, 1937 220-34-6459 74 Baltimore, MD. Director Usual Residence of Decedent or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Baltimore County Glen Arm 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21057 United States 11630 Glen Arm Road items death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 0 1 Never Married 2 Married à 72 hours after Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☐No Specify: Specify: 3 X Widowed 4 Divorced "natural" Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 N/A Own Home Home Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frances Scarbourgh Martin Wirtz permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Forest Hill, Maryland 21050 Mrs. Diane L. Trimble (Daughter) 3412 Baywood Drive 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State
(Baltimore County) Friday, Burial 2 Cremation 3 Removal from State Dulaney Valley Mem, Gardens 4 Donation 5 Other (Specify) Jan. 28, 2011 Timonium, Maryland Jeffrey I. Gair, Sr. Peaceful Alternatives Funeral & Cremetion Center. P.A. Signature of Funeral Service Licensee Lic.#M00677 Timonium, Maryland 2325 York Road 23a. In the file the diese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Central Vasculo A CCIDENT Onset and Death Immediate Cause (Final Physician/ month disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami that the death certificate be executed burial-transi and Due to (or as a consequence of): resulting in death) Last ng physician as the burial-Physician/Medical Box 68760 attending IF FEMALE: nse 23c. if yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death in the past 12 months? Po Month Day Year Pregnant at time of death ed by the a 9 Unknown P.O. I Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be det þ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24a. Was an 24b. Were autopsy findings available performed The certificate 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medica director, Be 26. Place of Death (Check only one) examiner? Other: 4 ursing Home 5 Residence 6 Other (Specify) 2 No ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 28b. Time of Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After t
completed filled in by the funera Natural work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifies Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Cartifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 701 CHA 5 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 10 25 PM Marie Helen kinus Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Morroll HOSPITAL Westminster 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** Country) 1 🗆 M 2 🗗 F Months PA Director 197-34-6458 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2XX No Carrol1 Westminster MD 10g. Citizen of What Country?
USA 10f. Zip Code 10e. Street and Number Funeral 21157 2144 Enoff Dr. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11 Marital Status Black White, to Armed Forces' þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Resturant Owner 8 Be pe filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Helen Marie Kreson Louis Kovach t. Page 1 and 2 should b tment of Health and Mer rtant: If item 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2144 Enoff Dr. Westminster, MD 21157 Louis Enoff (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 X Burial 2 ☐ Cremation XX Removal from State 1/25/2011 Greensboro, PA Monongahela Hill Cem; 4 Donation 5 Other (Specify) 21. Signature of Funeral Solvice 22. Name and Address of Facility Burrier-Queen Funeral Home and Crematory, 1212 W. Old Liberty Rd. Winfield, MD 21157 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph sician/ returbatio Cuncer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ung Mouss Sequentially list conditions, Examiner Due to or as a consequence of it any leading to immedicause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) rate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? acute mental 163 pictos After this certificate Presents with 1 Yes 2 No 26. Place of Death (Check only o e) . Was case referred to medical Be examiner? Hospital: 2 No Other: 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☑ No 1 Natural 5 \square Pending within 24 hours at er dea h.

To the Funeral Director: A completed filled it by the fi Accident Investigation the 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 21 DO0 69086 2011 dun 30. Name and address of person who completed cause of death (item 23a) (Type, Print) Westmintles 140 21157 Memorin 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State JAN 25 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Year Terry Franklin 10:57PM January 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A <u>Baltimore</u> <u>Seasons Hospice</u> 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🔀 F 1496771957 Maryland Director 53 211-50-2685 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1x Yes 2 ☐ No N/A Baltimore MD10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number Funeral U.S.A. 21215 2719 Liberty Heights 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces Black, White, etc. by 1 Never Married 2 XMarried 1 Yes 2X No Baltimore, Maryland 21215-0036 ☐ Yes 2 XNo Specify: If Yes, Give Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business Industry Keswick Nursing 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home & Rehab Certified Nurses assist. 12th Grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Doris Pratt Thomas Lovette 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3031 W. Pressman St., Baltimore, MD 21216 Daniel C. Franklin(husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

✓ Burial 2 ☐ Cremation 3 ☐ Removal from State 01/31/11 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) Garrison FOrest 22. Name and Address of Facility
Joseph H. Brown Jr., Funeral Home PA
2140 N. Fulton Ave., Baltimore, MD 21217 21. Signature f Funeral Service Licensee ALUYI eart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or neart failure. List only one cause on each line. Approximate Interval Between Onset and Death Hepatolellular Carcinoma Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Exåminer Sequentially list conditions Examiner Due to (or as a consequence of) if any, leading to immediate or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last been signed by the attending physician a should be detached for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year Dav 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an To the Hospital or Attending Physician: The law within 24 hours for death.

To the Funeral Infector After this certificate has! autopsy performed? 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 4 Nursing Home 5 Residence 6 Pother (Specify) examiner? 1 ☐ Yes 2 ☑ No Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA ျ Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number nský aprinem.o. 00057465 1/20/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W S Raya Pa KSt, M D 2835 SmJTN A Baltimore, MD, 21209 5-203. Smith AV. 31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 25 2011 Registrar

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Physician/ Month Gertrude Gabrielle Fellows P. M 4:50 January 20. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Baltimore **Examiner** 4b. City, Town, or Location of Death Towson Gilchrist Hospice 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Funeral Country)

New Jersey Days Hours Min 1 M 2 CXF Months 111-03-3096 92 Yrs. ່ 1918 Director Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Timonium Baltimore Maryland 1 ☐ Yes 2XXNo 10g. Citizen of What Country? United States 10e. Street and Number 10f. Zip Code 21093 12261 Roundwood Road of America 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes XXNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2XX No Specify: Completed 3XXVidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) B. Altman and Mental Hygiene. Elementary/Seconday (0-12) traumatic event, the High Fashion Buyer Department Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ unk. 19a. Informant's Name/Relationship (Type, Print) Personal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13 Devin Hill Road Unit Cl Baltimore, Maryland 21210 1 and 2 s of Health a item 27 i Mrs. Ann B. TenHoopen/Rep. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 Durial 2XXCremation 3 Removal from State January 21, Evans Funeral Chapel-Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 21. Signature of Funeral Service Licenses Peaceful Alternatives Funeral and Cremation Center, P.A.
2325 York Road Timonium, Maryland 21093 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 2 10 Medical Due to (or as a consequence of): Examiner rebrovers Sequentially list conditions ri any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): physician and s the bunal-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 1 Yes 2 9 Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ♣ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 certificate 1 ☐ Yes 2 ☐ No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: No No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🛣 Other (Specify) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1X Natural injury 5 Pending Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number R125808 11201 my 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Box 68760

P.O.

Records,

Division of Vital

Registrar

DHMH 17 Rev 7/2009

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1600 CRAIN HWY

Sufe 610, Glen Burnie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2, Date of Death Time of Death Month ANLIACC Physician/ ELLEN 8:55 A M FREW Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ANNE ARLINDEL Medical Center BURNIE Baltimore Washington Glen If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (111. y. 71yrs Days 203-30-2255 1 M 2 🔀 F Hours 1/25/1433 PA Director Usual Residence of Decedent fshow Department of Health and Mental Hygliene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoi any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits Director 1 🗆 Yes 2 🖰 No Glen Burnie Anne Arundel Maryland 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral USA 21061 5 Gilmore St Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces' Black, White, etc 1 Never Married 2 Married 1 Yes If Yes, Give Completed by 2 🔀 No 1 ☐ Yes 2 ☐ No Specify: altimore, Maryland 21215-0036 Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Anna Agnes Rowlands John Gleason 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Pasadena, Maryland 21122 8381 Oak Hollow Drive Daughter Mrs. Karen Topita 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Elkridge, MD 21075 Meadowridge Mem Park 1/26/2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Singleton Funeral & Cremation Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 M01121 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer Onset and Death Immediate Cause (Final Pnysician disease or condition Medical resulting in death) as a consequence of Cortontic **Examiner** 1 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events ١, duedynm and sigmaid colon attending physician and I for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be a within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the burn Division of Vital Records, P.O. Box 68760 If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death IE EEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 la 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by failurs, tailure 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 1 🗌 Yes 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Pactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) title of certifier 29b. Signature Date signed (Month, Day, Year) mo DOORS 21,2011 30. Name and address of person who co eted cause of death (Item 23a) (Type, Print) Glan Burnu JACOBS 305 MD Hospita 31. Date filed (Month, Day, Year)

JAN 25 20 32. Registrar's Signature State 201 Registrar DHMH 17 Rev 7/2009

DHMH 17 Rev 7/2009

Registrar

hn Gurklis		State of Maryland / Departme			lipie.	1440
		1- For State Certifica	ate of Death		a. No.	
Physici	an/	Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death)	3. Time of Death
edical Exami	ner	John Bradford Gurklis		Month January 20	Day Year , 2011	1113 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat	h	4c. County of Death	
		70 Jumpers Circle 5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Nottingham Iday) If Under 1 Year If Under 24Hr	. Is Date of Birth	Baltimore Cou	-
Funeral Director		045 60 0456 1/	Months Days Hours Min	1	Foreig	n Mr
		217-60-2476 1 M 2 F 58 Usual Residence of Decedent	Yrs.	10/25/	1952 6	untry) MD
ku a		10a. State 10b. County 10c. City, Town of	or Location			10d. Inside City Limits
nd show	≍	MD Baltimore King	sville			1 Yes 2 No
faryla 28a-f I at o	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cour	ntry?
3a or	Ē	11823 Chapman Rd.	21087		USA	
then then	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married Armed Forces?	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerte 		14. Race - Ameri White, etc.	can Indian, Black,
or it	Ē	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year		,	Specify: Wh	ite
rural ap	by	l or Dates:	1 Yes 2 No specify: Decedent's Usual Occupation (Give kind of	work done	16b. Kind of Business/I	
72 hou	etec	Elementary/Secondary (0-12) College (1-4 or 5+)	uring most of working life. DO NOT use rel	ired)		_
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Insportant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	7	1 1 1 1	1823 Chapman Rd.		•	
e, N t and t Health item trau		20a. Method of Disposition 20b. Place of	Disposition (Name of cemetery.		20c. Location - City or	
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Baltimore, permit. Pages 1 ar Department of Hee Important: If ite injury or other tr		21. Signature of Funeral Service Licensee	22. Name and Address of FacilityCAF	A/Steph	nen D.Loh	rmann P.A
E.E.G.E.		Rebersa Aockermon	8717 Green Past	ures Dr	Balto,	MD 21286
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Chronic alcoholis	sm complicated by h	ypothermi	La	Death
		but to (or do d correctables or).				
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated vents resulting in death 1 ast Due to (or as a consequence of):				
e executed bian and dial - transit		events resulting in death) Last Due to (or as a consequence of): d.				
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tox 68760, eath certificate be attending physici for use as the buri	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23c. If yes, outcome of yes, yes, yes, yes, yes, yes, yes, yes,	er ME g913 3/3/11 T	L	23d. Date of delivery	
certification ce	ian	23b. was decedent pregnant in the past 12 months? 1 Live birth 2 pregnant at time of death 5	Fetal death 3 Ectopic pregna	ancy	Month D	ay Year
Box 68760, e death certificate but the attending physic et for use as the but	Physician/Me	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)			
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Records, P.O. The law requires that th ficate has been signed by	ed by			1 Yes		ably 4 🗹 Unknown
Cords law requests been been been been been been been bee	Completed			24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
Recort The la	mo;			perform 1 ✓ Yes 2		2 No
Vital Rec hysician: The this certificate I director, page	Be	25. Was case referred to medical examiner?	26 Place of Death (Check	only one)		
Division of Vital ral or Attending Physician: rs after death. In Director: After this certiced in by the funeral director.	2	1 ✓ Yes 2 No Inpatient 2 ER/Out			esidence 6 🗸 Other:	
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isior Attend or death rector: by the	icat	2 X Accident Investigation Investigation 28e. Place of Injury - At home, far	m, street, factory, office building, etc.	Vas expos	sed to cold	al Route Number. City
Divipital or ours after Direction Di	Certification:	3 Suicide 6 Could not be determined (Specify) fd residence		or Town, Sta Nottingh	eet and Number or Rur te) 70 Jumper nam, MD	s Circle
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the bur		29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, deat	h occurred at the time, date and place, and			d.
To the Hos within 24 h To the Fur	Medical	one) 2 Medical Examiner: On the basis of examination and/or invariant manner stated.	vestigation, in my opinion, death occurred a	at the time, date ar	nd place, and due to the	cause(s)
	Σ	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mon	
2,00		(Cathenia)	O.C.M.E.		January 21, 2011	
Onthe		30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 900 N	N Baltimore Street Baltimore	MD 21223		
	ate	31. Date filed (Month, Day, Year) 22: Registrar's Signature				
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene

Velett B. Closs		Certificate of Death	Reg. No.	
Physician/	Decedent's Name (First, Middle,Last)		Date of Death Month Day Year	3. Time of Death
Medical Examine	Everett Benjamin Gross 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	January 16, 2011 4c. County of Death	1504 hrs
3	1812 West Pratt Street, Apt. 2	Baltimore	N/A	·
<i>}∗v</i> Funeral	5. Social Security Number 6. Sex 7. Age (In ye	rs. last birthday) If Under 1 Year If Under 24Hrs	8. Date of Birth(MM/DD/YYYY) 9. Bir	
Director	214-62-6244 1KM 2F 56	6 Yrs. Months Days Hours Min	07/25/1954	ountry) MD
, any		City, Town or Location		10d. Inside City Limits
f show	MD N/A	Baltimore		1 XYes 2 No
the Maryland a or 28a-f sh stiffed at one	10e. Street and Number	10f. Zip Code	10g. Citizen of What Cou	ntry?
ith the	1812 Pratt Street Apt 2 11. Marital Status 12. Was Decedent Ever i	n U.S. 13. Was Decedent of Hispanic Origin? (Sp	U.S.A.	ican Indian, Black,
r death with or items 23 must be no Funeral	1 X Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto		
ral", or	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 No specify:	Specify: Bla	
hours :	15. Decedent's Education (Specify only highest grade completed	d) 16a. Decedent's Usual Occupation (Give kind of videring most of working life. DO NOT use reti	work done 16b. Kind of Business/ ired)	Industry
36 iin 72 than "dical 1	Elementary/Secondary (0-12) College (1-4 or 5+)	Disability	N/A	
5-0036 ed within 72 hour lygiene. other than "nature Medical Exam	12th Grade 17. Father's Name (First, Middle, Last)		(First, Middle, Maiden Surname)	
21215-0036 Mental Hygiene. marked other than c event, the Medica	Unk	E. Thomas		
and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 23a-f sho traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or I		
and 2 sho fealth and traumati	Linda Hilton(sister) 20a. Method of Disposition	3127 Normount Ave. Ob. Place of Disposition (Name of cemetery,	Date 20c. Location - City or	Town, State
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 23a-f she or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify:	Joseph Brown F/H And Crematory 01/	/21/11 Baltimor	re.MD
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Division of Vital Records, P.O. Box 687 alor Attending Physician: The law requires that the death certific rs after death. *I Director: After this certificate has been signed by the attending per led in by the funeral director, page 2 should be detached for use as the refification: To Be Completed by Physician/	1 Yes 2 No 9 Unknown g Unknown	of death 5 Other (Specify)		
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Division o Division o spital or Attending sours after death. meral Director: After filled in by the func Certification:	3 Suicide 6 X Could not be 28e. Place of Injury -	At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Re or Town, State)	
Dospital hours hours y filled		[ulti-family apartment wledge, death occurred at the time, date and place, and	1812 W. Pratt St.	
Division of Vital Records, To the Hospital or Attending Physician: The law requiremental hours after death. To the Funeral Director: After this certificate has been seempletely filled in by the funeral director, page 2 should Medical Certification: To Be Complete.	one) 2 Medical Examiner: On the basis of examination	on and/or investigation, in my opinion, death occurred	at the time, date and place, and due to the	ne cause(s)
	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mo	
	Carde Hallan	O.C.M.E.	January 17, 201	1
HETA	 Name and address of person who completed cause of death (Carol H. Allan, MD Assistant Medical Exami 	(Item 23a) iner 900 W. Baltimore Street, Baltimore	, MD 21223	
State	31. Date filed (Month, Dev Year) 32. Registrar's Sig			
Pogiatra	SIAN 9 5 7011 75	THE ALL AND THE		

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JANUARY 19, 2011 RUTH GOODMAN 11:00 PM Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1 HIGH STEPPER COURT, BALTIMORE BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Min 12/24/1920 Director 216-12-0319 90 MD Usual Residence of Decedent or 28a-f show er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director BALTIMORE 1 Yes 2 X No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1 HIGH STEPPER COURT, #202 21208 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. "natural", Completed 3 X Widowed 4 Divorced WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) 12 College (1-4 or 5+) HOMEMAKER OWN HOME any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 HYMAN CAPLAN ROSE LEVIN permit. Page 1 and 2 should be Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SARELLEN LEVINE/DAUGHTER 1711 BY WOODS LANE, STEVENSON, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ★Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place)
ARLINGTON CHIZUK
AMUNO CEMETERY 01/23/2011 BALTIMORE, MD Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury sician and burial-transit death certificate be executed that initiated events resulting in death) Last Due to (dr/as a consequence of) Physician/Medical as the nding I IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy for 5 Other (specify) Month Pregnant at time of death Day ned by the a e detached i Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed death? Hospital or Attending Physician: The 1 Yes 2 No 2 N Yes funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗷 No Other: ဂ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work hours after death. uneral Director: Aft ad filled in by the fur 2 Accident
3 Suicide
4 Homicide 1 🗌 Yeş 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed within 2 the only one 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified 00 Name and address of person who do pleted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 5 Registrar

DHMH 17 Rev 7/2009

Baltimore,

Box 68760

Records,

Division of Vital

	For State Registrar		•	Department of Healt Certificate of Deat	h	Reg. No.	UII.	01420
an/	1. Decedent's Name (First, Middle, L ANITA	ast)		GOLDBERG	2. Date of Do Month JANUAR	Day	Year 2011	3. Time of Death 10:10 P
cal ier	4a. Facility Name (if not institution, gi	ve street and number)		4b. City, Town, or Locati			ounty of Death	
	SUNRISE OF PIKE 5. Social Security Number 6.		e (In yrs. last birth	PIKESVILL	E der 24 Hrs. 8. Date of Bi		BALTIMO	
	056-16-9078	1 □ M 2 🖾 F	90	Months Days Hour		71920	Cou	nplace (State or Foreign ntry) NY
ō	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
irect	MD BALTI	MORE	OWINGS	MILLS				1 ☐ Yes 2 💢 N
Funeral Director	10e. Street and Number 3410 ASSOCIATED	WAY #401		10f. Zip Code 21117		10g. Citize	en of What Cou	intry? USA
Fune	11. Marital Status	12. Was Decedent E	ever in U.S.	13. Was Decedent of Hispanic If Yes, specify Cuban, Mex		- 14	. Race - Ameri	can Indian,
d by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🎇 Divorced	1 ☐ Yes 2 ☒ If Yes, Give Year or Dates.	No	1 ☐ Yes 2 🖾 No Spec		Sp	Black, White, pec <i>ify:</i> WHI	
olete	15. Decedent's (Specify only highest of	Education	16a.	 Decedent's Usual Occupation (Give kind of work done during n	nast of warking	16b. Kind	d of Business Ir	
Completed	Elementary/Seconday (0-12)	College (1-4 or 5	+)	life. DO NOT use retired)	KEEPER		A C C O I	UNTING
Be	17. Father's Name (First, Middle, Last				other's Name (First, Middle	, Maiden Su		MIING
욘	HARRY			•	ARY	<u>.</u>	LEIN	
	19a. Informant's Name/Relationship FRAN HERSHFIELD		I	Mailing Address (Street and Nur 1415 COLD BOTT)				
	20a. Method of Disposition 1 M Burial 2 Cremation 3	- 	20b. Place of	Disposition (Name of y, crematory or other place)	Date	T	ation - City or T	
	4 Donation 5 Other (Spe	cify)		PARK CEMETERY			RAMUS,	
	21. Signature of Funeral Service Lice	house .	_	22. Name and Address of Fa 8900 REISTE	RSTOWN ROAD,			
	23a. Part 1. Enter the disease, or co shock, or heart failure. List only	mplication, that caused one cause on each line	the death. Do no					Approximate Interval Between
	Immediate Cause (Final disease or condition resulting in death)	_ a	890 M	W HRAN	tallu	10_		Onset and Death
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xamıner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	a consequence o	f):				
Exau	that initiated events resulting in death) Last	c. Due to (or as a	a consequence o	f):				
ica		d						
/Mec	IF FEMALE:	23c. If yes, outcome	of pregnancy					
ician	23b. Was decedent pregnant in the past 12 pronths? 1 ☐ Yes 2 ☐ No	1 ☐ Live Birth 4 ☐ Pregnant at	2 🗌 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23	d. Date of delive Month	very Day Year
Physician/Medical	9 ☐ Unknown Part II. Other significant conditions	9 Unknown	ut not regulting in	the underlying cause siven in P	lort I oo - Did.			the cause of death?
d by	Fait ii. Other significant conditions	contributing to death b	at not resulting in	The underlying cause given in F	2001 210		No 3 \square Pro	\ /
Completed by					24a. Was		24b. Were auto	opsy findings available
ا ق			_		auto perf 1 □ Yes	orme@?	death?	'_
8 R	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		Other: A	Death (Check only one)			
و: ا د	27. Manner of De 1h	28a. Date of injur (Month, Day	ry 28b. Ti	me of jury 28c. Injury at work?	Nursing Home 5 Resi 28d. Describe			y)
	1 Natural 5 ☐ Pending 2 ☐ Accident Investigati 3 ☐ Suicide 6 ☐ Could not	on		M 1 ☐ Yes 2				
rinca	4 Homicide determine			m, street, factory, office		(Street and N wn, State)	iumper or Rura	il Route Number,
			mu lenguale de e	eath occured at the time, date a	nd place, and due to the ca	ause(s) and r	manner as state	ed.
	29a. Certifier 1 Certifying Ph	ysician: To the best of a miner: On the basis of expenses of expen	kamination and/or	investigation, in my opinion, deat	h occurred at the time, date	and place, ar	Id due to the ce	ause(s) and manner stat
Medical Certificate:	(Check 2 L Medical Example (Check L Medical Example)	niner: On the basis of ex	kamination and/or	investigation, in my opinion, deat edge, death occurred at the time, of 29c. License number	h occurred at the time, date date and place, and due to the	he cause(s) a		tated.
Medical	(Check 2' Medical Examonly one) 3 Certifying Nu	niner: On the basis of ex	kamination and/or	investigation, in my opinion, deatledge, death occurred at the time, of	h occurred at the time, date date and place, and due to the	he cause(s) a	nd manner as s	tated.

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 21, 2011 Linda Peach Groeber 6:45 P. M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Baltimore County Towson If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, . Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Months 162-34-5102 Director 68 15, 1942Cincinnati, Chio October Usual Residence of Decedent 28a-f show 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director Baltimore County Maryland Timonium 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9 Bailiffs Court 21093 United States Page 1 and 2 should be filed within 72 hours after death \nextra free Health and Mental Hyglene.
ant: If item 27 is marked other than "natural", or items uny or other traumatic event, the Medical Examiner m. uny or other traumatic event, the Medical Examiner m. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4 X Divorced Specify: White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) School Administrator Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Katherine Wellham John Francis Peach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryn Groeber (Daughter) 1137 S.Clinton Street Baltimore, Maryland 21224 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel and Cremation Services Inc. 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o (Harford County) 1 🗌 Burial 2 🔀 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jan. 23,2011 Forest Hill, Maryland Signature of Funeral Service Licensea, Jeffrey L. Gair, Sr. Peaceful Alternatives Funeral & Cremetion Center, P.A. Lic.#M00677 2325 York Road Timonium, Maryland 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final VNO Cancer Ph, sician/ disease or condition resulting in death) nonthi Medical Due to (or as a Jonsequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 Who

9 Unknown 4 Pregnant 9 Unknown Pregnant at time of death ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed Completed by Covenery overy chrecor 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 ☐ Yes 2 ☐ No Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\tau \) Nursing Home 5 \(\tau \) Residence 6 \(\tau \) Sother (Specify) \(\tau \) \(\tau \) 0 1 Inpatient 2 ER/Outpatient 3 DOA After this upleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 □ Yes 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending death. 2 🗌 No Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier

Registrar DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO 6701

32. Registrar's Signature

CHAMES

29b. Signature and the of certifier

AARON

31. Date filed (Month, Day, Year)

25

(Check only one)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

N-Cumbs

29c. License number

5

58303

TONSON

29d. Date signed (Month, Day, Year)

Janvar

2011

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	147	J	U

State		tificate of Death						
Registrar 1. Decedent's Name (First, Middle, Last)		imoute of Death	2. Date of De	Reg. No.	3. Time of Death			
Physician/ RID ALL GORIVAS	10		Month	23 20/1	1 644 PM			
Examiner 4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location		4c. County of De				
Seasons Hospice at Northwest		Randal1st			nore Co.			
Director 153-18-8833 NXM 2 □ F 9	yrs. last birthday) O Yrs.	If Under 1 Year If Under 1 Months Days Hours	er 24 Hrs. 8. Date of Bi Min. (Month, Di 11/04	ay, Year)	Birthplace (State or Foreign Country) W Jersey			
Usual Residence of Decedent 10a. State 10b. County 10	c. City, Town or Loc	cation			10d. Inside City Limits			
Maryland Anne Arundel Co.	Linthicu	ım Heights			1 ☐ Yes 2 🔀 No			
10e. Street and Number		10f. Zip Code		10g. Citizen of What				
300 Jerlyn Avenue 11. Marital Status 12. Was Decedent Ever			090	United				
12. Was Decedent Ever Armed Forces? 1 Never Married 2 Married 1 Never Married		Nas Decedent of Hispanic C f Yes, specify Cuban, Mexic		14. Race - Ar Black, Wi	nerican Indian, hite, etc.			
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Political property of the political property	N. D. D. D. D. D. D. D. D. D. D. D. D. D.							
Joseph Gervasio Joseph Gervasio 19a. Informant's Name/Relationship (Type, Print) Ms. Annette M. Gervasio/Daug		ng Address (Street and Num						
Ms. Annette M. Gervasio/Daug	shter 63	397 Centennia		len Burnie				
20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	cemetery, cren	natory or other place)	Date		nie, Maryland			
Ms. Annette M. Gervasio/Daug 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Fundal Struce Libertee M0		Crematory 2. Name and Address of Fac	01/25/2011					
21. Signature of Fundal Sprince Liber ee MO)1121 Se	rvices PA: 1	2nd Ave SW	: Glen Bur	nie, MD 21061			
23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one pause on each line	e death. Do not ente	er the mode of dying, such a	as cardiac or respiratory a	arrest,	Approximate Interval Between			
Physician disease or condition a.	rey 1	isead			Onset and Death			
Medical resulting in death) Examiner Diff to (or as a co	onse wence of):	12						
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g Unknown Part II. Other significant conditions contributing to death but r	not resulting in the u	underlying cause given in Pa	art I. 23e. Did	tobacco use contribute	e to the cause of death?			
The contraction of the contracti			- 1		Probably 4 Unknown			
The law requires are has been signage 2 should be completed			24a. Wa		autopsy findings available			
ne law age 2			per	formed? death	to completion of cause of 1? Yes 2 \sum No			
25. Was case referred to medical examiner?			eath (Check only one)	- KI	19-0'01			
25. Was case referred to medical examiner? 1 Ves 2 Ves	2 ER/Outpatier		Nursing Home 5 Re		pecify)			
27. Manner of Death 28a. Date of injury (Month, Day, Yo		t 28c. Injury at work? M 1 □ Yes 2	_	e how injury occurred				
27. Manner of Death 1 Solution 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2	- At home, farm, str	reet, factory, office		(Street and Number or own, State)	Rural Route Number,			
≥ b # 5 = 0 Dullding, etc. (S	Connifi()							
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29a. Certifier 1 Check 2 Medical Examiner: On the best of my Medical Examiner: On the basis of examons, only one) 3 Certifying Nurse Practioner: To the best of my Medical Examiner: On the basis of examons, only one) 3 Certifying Nurse Practioner: To the best of my Medical Examiner: On the basis of examons, only one) 3 Certifying Nurse Practioner: To the best of my Medical Examiner: On the basis of examons, only one) 3 Certifying Nurse Practioner: To the best of my Medical Examiner: On the basis of examons, only one) 3 Certifying Nurse Practioner: To the best of my Medical Examiner: On the basis of examons, only one) 3 Certifying Nurse Practioner: To the best of my Medical Examiner: On the basis of examons, only one) 3 Certifying Nurse Practioner: To the best of my Medical Examiner: On the basis of examons, only one) 3 Certifying Nurse Practioner: To the best of my Medical Examiner: On the basis of examons, only one) 3 Certifying Nurse Practioner: To the best of my Medical Examiner: On the basis of examons, only one) 3 Certifying Nurse Practioner: To the best of my Medical Examiner: On the basis of examons, only one) 3 Certifying Nurse Practioner: To the best of my Medical Examiner: On the basis of examons, only one) 3 Certifying Nurse Practioner: To the best of my Medical Examiner: On the basis of examons, only one) 3 Certifying Nurse Practioner: To the best of my Medical Examiner: On the basis of examons, only one) 3 Certifying Nurse Practioner: To the best of my Medical Examiner: The basis of examons of the basis of examons of the basis of the basis of examons of the basis of examons of the basis of t	Specify) / knowledge, death	stigation, in my opinion, death	nd place, and due to the	cause(s) and manner as	the cause(s) and manner stated.			
200 Cartifier 1 Cartifier Physician: To the hest of my	Specify) / knowledge, death	stigation, in my opinion, death	nd place, and due to the n occurred at the time, date date and place, and due to	cause(s) and manner as	the cause(s) and manner stated.			
ASIA ON IL	/ knowledge, death mination and/or invess of my knowledge,	stigation, in my opinion, death death occurred at the time, d	nd place, and due to the n occurred at the time, date date and place, and due to	cause(s) and manner as a and place, and due to the cause(s) and manner 29d. Date signed (Mo	the cause(s) and manner stated. r as stated. onth, Day, Year)			
30. Name and address of person who completed cause of deat	/ knowledge, death mination and/or invest of my knowledge, the (Item 28a) (Type, F	stigation, in my opinion, death death occurred at the time, d	nd place, and due to the n occurred at the time, date date and place, and due to	cause(s) and manner as a and place, and due to the cause(s) and manner 29d. Date signed (Mo	the cause(s) and manner stated.			

Registrar

DHMH 17 Rev 1/2001 OCME 2006

State

OCME

Donna M. Vincenti, MD 31. Date filed (Month, Day, Year)

IAN 25 2011

Assistant Medical Examiner

32. Registrar's Signature

ORIGINAL

900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 21^y, 2011^{ear} 2:26 DOLORES T. GIGLIETTE January p_{M} Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Tate Hospice Linthicum Anne Arundel Social Security Number 6. Sex . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** August 19 Months Days Hours Min 214-18-7552 89 Mary Land Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County notified at 10c. City. Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Glen Burnie 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Examiner must be Funeral with 23a 12 Lincoln Avenue S.W. 21061 U.S.A. items 72 hours after death Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status Was Decest. Armed Forces? 1 ☐ Yes 2 🗷 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", 3 X Widowed 4 Divorced Completed traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Seconday (0-12) Housewife Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Mabel 1 Raymond Lohn Zœller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7940 Cobbler Lane, Pasadena, Maryland 21122 Paula Sandidge (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ō 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State injury 4 Donation 5 Other (Specify) Cedar Hi/11 Cemetery Jan. 25, 2011 | Brooklyn Park, Maryland Signature of Funer Vice License 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasdadena, Maryland 21122 23a. P. ... Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Physician ase or condition sulting in death) 0770 Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 4 Pregnant Day Year Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed in page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy perform prior to completion of cause of death? certificate 2 No 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, to Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check the Certifying Hurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b Signature and title of certific 29d. Date signed (Month. Dav. Year) e and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State Registrar JAN 2

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JOHN R. GRAY 19y Physician/ January 2011 12:59 рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Annapolis Anne Arundel Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🕅 M 2 🗆 F Months August 22 .^{Yea}[1942 Mary Land 216-40-1521 68 Director Usual Residence of Decedent 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State filed within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🕱 No Maryland Anne Arundel Crofton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21114 U.S.A. 7511 Crofton Colony Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian. Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Completed by 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced "natural", Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Is 16a, Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Seagrams Distillery Tank Operator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bertha Rizzo ပ Grav Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7511 Crofton Colony Drive, Crofton, Maryland 21114 Mary F. Gray (Wife) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Jan. 20, 2011 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Creaatory 22. Name and Address of Facility McCully—Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 21. Signature of Fur ral Service Licer 234. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Ph sician/ disease or condition resulting in death) -0100 Medical Examiner Due to (or as a consequence of): Sequentially list conditions. Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or liniury and -trans that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a I for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 4 No ၉ 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 [29b. Signature and title of certifier YOCOUH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOURIN 6001

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JAN 25 201

32. Registrar's Signature

For	State of Maryland / Department of Health and
State	Certificate of Death

100	100	1	9	8	2

Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Physician \mathbf{P}^{M} Maryann S Hutchinson 19 01 2011 5:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Collington Episcopal Life Care Center Mitchellville Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, **Funeral** Year) Months Days Hours Min 1 □ M 2**X** F 489-58-6162 Director Apr 30, 91 1919 Maine Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Directo Maryland Mitchellville Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a 10450 Lottsford Road Arbor 3-40 20721 United States Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 【XNo Baltimore, Maryland 21215-0036 9 2 If Yes, Give Year or Dates: 1 ☐ Yes 2 🔀 No Specify. Specify: 3 Widowed 4 ☐ Divorced White "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be i Leland Small ၉ Essie (unk) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Rhonda H. Luckey/daughter 68 Shady Drive Indiana, Pennsylvania 15701 Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 1/25/2011 Woodbine, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Promo Beverly L. Heckrotte, P.A. Clarksville, MD 21029 M00957 Manuta 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Failure to Thrive disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Advanced Dementia Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to or as a consequence of sician and burial-transit be executed Due to (or as a consequence of): Box 68760 physician Physician/Medical the attending ph IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year Day 5 Other (specify) P.0. detached 9 Unknown signed by be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ Hypothyroidism 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate l perforn 2X No 2 🗆 No 1 ☐ Yes 1 ☐ Yes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Tes 2 No Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred or Attending 5 ☐ Pending investigation death. ours after death.

neral Director; /
filled in by the for 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 2 29b. Signature and title of certific 29c. License number 29d. Date signed (Month. Day, Year) D66658 January 20, 2011 1 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rexford A. Babilah, 7500 Hanover Parkway, Suite 101A Greenbelt, MD 20770

State Registrar

M.D.

For		State of Ma	-		f Health and N	vlental Hygie	ne-	
State Registrar			C	ertificate o	f Death	Reg	No.	
	(First, Middle, Las	•				2. Date of Death Month	Day Year	3. Time of Death
Wi	Iliam E	. Hayes	Jr.			1 3	0 201	1 4:15 PM
. Facility Name (if	not institution, give	street and number)		4b. City, Tow	n, or Location of Death		4c. County of De	
rankl	in Sque		pital	ROSE		0.0.1. (8)	Ba/+	
Social Security No 217–64		M 2 G F	ln yrs. last birthda 58 Yrs	Months D	ys Hours Min.	8. Date of Birth (Month, Day, Ye Jan . 30	1052 9.B	sirthplace (State or Foreign ountry)
sual Residence of			30			pair.30,	1932	MD
a. State	10b. County		10c. City, Town or	Location				10d. Inside City Limits
MD	Baltim	ore	Ro	sedale				1 🗆 Yes 2 🛣 No
e. Street and Nun				10f. Zip Co		10g	. Citizen of What C	Country?
10 Alt	on Cour	t		21	237		USA	
. Marital Status		12. Was Decedent E Armed Forces?	ver in U.S.	3. Was Decedent	of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Am	
	ed 2 Married	1 Yes 2 X	No	1 Yes 2 X		riioari, etc.,	Black, Wh	
3 Widowed		Year or Dates.					эреспу.	White
(Spe	15. Decedent's Ed cify only highest gra		1 (G	cedent's Usual Or ve kind of work do	ne during most of work	ding 16	b. Kind of Busines	s Industry
Elementary/Seco		College (1-4 or 5		.DO NOT use ret isabled	red)		Disable	đ
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		ayes Sr.				F. Bri		
	me/Relationship (Ty		10h M	ailing Address (St	eet and Number or Rur	al Poute Number Cit	y or Town State	Zin Code)
	rd Haye				Road St			LIP 0000)
a. Method of Disp	_	· · · · · · · · · · · · · · · · · · ·	20b. Place of Di	sposition (Name o		Date 20	c. Location - City of	or Town, State
	☐ Cremation 3 ☐ 5 ☐ Other (Specify	Removal from State	Hollv	rematory or other Hill Ce	^{place)} mete r y 1,	/24/11	Baltimo	re MD
	eral Service Licens		12	22. Name and A			7.110 P.o.	1+o MD
) Att	11/10 10	2 Fil	us		. 5(00 Mace		sex 21221
3a. Part 1. Enter t	ne disease, or comp	olications that caused	the death. Do not		dying, such as cardiac		e or ha	Approximate
shock, or hear nmediate Cause (,	ne cause on each line						Interval Between Onset and Death
isease or condition is east or condition is suffing in death)		a. Due to for an	a consequence of):	HYPO	110			-
		To to 1	consequence on.					
equentially list co	nditions,	b. Existe for as a	consecuence of:	Thmic				
a y, each g to m ause. Enter Under ause (Disease or	lying	cord	O DOSC	lular	Diseas	n		
nat initiated events esulting in death) t	ast	Due to (or as	consequence of):	1 41 141	D17600	<u> </u>		
	L	d						
		-						
FEMALE: 3b. Was decedent in the past 12 r 1 Yes 2	nonths?	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal death	3 Ectopic preg 5 Other (specif			23d. Date of d Month	delivery Day Year
g 🗌 Unknown					and the Post of			
rt II. Other signif	cant conditions co	ontributing to death b	ut not resulting in th	e underlying caus	e given in Part I.			to the cause of death?
-			_			1 🗆 Yes	2 No 3 🗆	Probably 4 🗆 Unknown

≁nysician/ Medical **Examiner**

Physician/ Medical

Examiner

1 XYes

27. Manner of Death 1 Natural 2 Accider 3 Suicide

Accident Suicide

4 Homicide

2 🗌 No

5 Pending

Investigation 6 Could not be

determined

Director

Funeral

Completed by

Be

မ

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Be Completed by Physician/Medical မ Medical Certificate:

Division of Vital Records, P.O. Box 68760

FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregnancy 1	3 Ectopic pregnancy 5 Other (specify)
	s contributing to death but not resulting in	the underlying cause given in Part
Was case referred to medical examiner?		26. Place of Dear
examiner:	Hospital:	_ Other:

			1 Yes 2 No 3 Probably 4 Unknown
			24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No
		26. Place of Death (Che	ck only one)
spital: 1 Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nursing F	Home 5 ☐ Residence 6 ☐ Other (Specify)
28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
28e. Place of Injury - At h building, etc. (Specif		pry, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
			and due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s) and manner stated

-JAW GARY

30, 2011

054725

29a. Certifier	1 Certifying Physician: To the best of my knowledge, death oc							
(Check								
only one)	Certifying Nurse Practioner: To the best of my knowledge, de	ath occurred at the time, date and place, and due to	the cause(s) and manner as stated.					
29b. Signature a	and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)					

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bultimore, mo Square drive 31. Date filed (Month, Day, Year)

JAN 25 2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 5:18 AM Elizabeth M. Henderson January 24, Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Riverview Care Center Baltimore Essex 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Days Hours Min. (Month, Day, Year) Director 69 <u> 216-36-5174</u> Marvland Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 Yes 2 No MD Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States Eastern Blvd 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates Specify 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) t. Page 1 and 2 should be filed wit rtment of Health and Mental Hygie rtant: If item 27 is marked other i jury or other traumatic event, th Medical Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph Kircher Agnes Beatty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Frank /Daughter 8356 Old Philadelphia Road Rosedale, MD 21237 Baltimore, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If i any injury or or cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Jan 25 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory 2011 Signature of Funeral Service Licensee 22. Name and Address of Facility W01442 Cremation and Funeral Alternatives Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Interval Between Onset and Death Suspect Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner orano (Citozon Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician. The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death 9 Unknown 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? Yes 2 No page After this certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 100 မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work?
1 Yes 2 No 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4

Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

29b. Signature and title of certifier

31. Date filed (Month, Day,

Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MALICA DABAM. FOG. 6

DHMH 17 Rev 7/2009

State Registrar ASTERN BLUP - M.D - 21221.

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

		_	1 - State Registrar	Certificate of Death	Reg	, No.				
	Physicia	ın/	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year							
	Medi	cal	WALTER CHARLES HEDLEY		January	2Î ^y , 2ÕÏ1 8:35 Рм				
	Examir	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of	Death	4c. County of Death Baltimore County				
	Funeral	_	224 Purlington Road 5. Social Security Number 6. Sex 7. Age (In yrs. last bir	Timonium rthday) If Under 1 Year If Under 2	4 Hrs. 8, Date of Birth	9. Birthplace (State or Foreign				
	Director		200-12-8309	Yrs. Months Days Hours	Min. (Month Day Ye	1926 Pennsylvania				
	land shov d at	호	10a. State 10b. County 10c. City, Tow	vn or Location		10d. Inside City Limits				
	Mary 28a-f otifie	i.ec	Maryland Baltimore County	Timonium		1 ☐ Yes 2 🛣 No				
	s 23a or	Funeral Director	10e. Street and Number 224 Purlington Road	10f. Zip Code 21093	. 10g	g. Citizen of What Country? USA				
	death item ner n		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican,	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.				
21215-0036	urs after tural", or al Exami	Completed by	1 ☐ Never Married 2 ☐ Married 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates. WWII	1 ☐ Yes 2 ሺ No Specify:		Specify: White				
15-	72 ho n "nat ledica	nple	15. Decedent's Education 16a (Specify only highest grade completed)	a. Decedent's Usual Occupation (Give kind of work done during most of	of working 16	b. Kind of Business Industry				
12	ithin iene.	Sol	Elementary/Seconday (0-12) College (1-4 or 5+)	ife. DO NOT use retired) Engineer		Manufacturing				
p	iled w I Hyg othe	æ	17. Father's Name (First, Middle, Last)		's Name (First, Middle, Maid					
/lar	d be f denta arked aric ev	욘	Walter Charles Hedley Sr.	Kath	ryn Jane Her	nningsen				
Maryland	shoul and P is ma		(-)	b. Mailing Address (Street and Number						
	and 2 lealth		` ' ' ' '	24 Purlington Road	<u> </u>	<u> </u>				
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green	of Disposition (Name of ery, crematory or other place) Mount Crematory 1		c. Location - City or Town, State				
Ball	Departing Departing Important any in once.	i	21. Signal France Serve Livere Martin D. Lawson	2017CHECTENTEDER	ELD FUNERAL Baltimore,	HOME INC 21212				
	Physician/ Medical	20 12	23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		ardiac or respiratory arrest,	Approximate Interval Between Onset and Death				
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38760	icate g phys	/Medical	d							
_	ath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1	th 3 Ectopic pregnancy		23d. Date of delivery				
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rds	equire een s nould	eted				2 No 3 Probably 4 Unknown				
Division of Vital Records,	The lay ate has page 2	Completed by			24a. Was an autopsy performed 1 \(\text{Yes} \) 2	24b. Were autopsy findings available prior to completion of cause of death? No 1 □ Yes 2 □ No				
tal	cian: sertific ector,	Be	25. Was case referred to medical examiner? [Hospital:	26. Place of Death						
Ę	Physi this c	- To	1 Inpatient 2 ER/Ou		sing Home 5 Residence					
ion o	tending leath. or: After the funer	Certificate:		Time of injury at work? M 1 Yes 2 N	28d. Describe how i	njury occurred				
Divis	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,		4 Homicide determined 28e. Place of Injury - At home, fa building, etc. (Specify)		City or Town, S	- 1				
	he Hosp in 24 hoo he Fune pleted fi	Medical	29a. Certifier (Check (Check only one) 1	or investigation, in my opinion, death occu	urred at the time, date and p	lace, and due to the cause(s) and manner stated.				
_	Vith To the com	-	29b. Signature and title of certifier	29c. License number	29d.	. Date signed (Month, Day, Year)				
			Carries my	D53445	JA	NUADY 24,2011				
			30. Name and address of person who completed cause of death (Item 23a) (Robert T. Turner, MD, 7600 Osler	Drive, Suite #311		,				
	Stat		31. Date filed (Month, Day Year) 32. Registrar's Signature	arkal						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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			Certificate of Maryland / Department of Certificate of		Wieritai Fry		
			1. Decedent's Name (First, Middle, Last)	Deaiii	2. Dete of De	Reg. No.	3. Time of Death
п	Physicia	an	1.1		Month	Dey	Year
1	/Medic		4a Fecility Name (If not institution, give street and number)	4b. City, Town, or	Location of Dear		9011 11:10 am
	Examin			o At	more	10. 202,	NIA
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year			rth Value	Birthplace (State or Foreign
	Director		217-58-1033 17 M 2□ F 58 Yrs. Months Days	Hours Min.	July .	rth 15,1952	Washington DC
	2		Usual Residence of Decedent				
	anylar show		10a. State 10b. County 10c. City, Town or Location Edg	gewater			10d. Inside City Limits
	Ba-f	5					1 ☐ Yes 2 ☐ No
	ith th	吉	10e. Street end Number 10f. Zip Code PO Box 444	01007		10g. Citizen of V	
	ath v	Funeral Director		21037		United	
	er de Rem	Š	11. Maritel Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of If Yes, specify Cut	Hispanic Origin? (S ban, Mexican, Puerl	pecify Yes or No o Rican, etc.)	Blac	e - American Indian, ck, White, etc.
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Maryland 21215-0020	s 1 end 2 should be filed within 72 hours after death with the Maryland f Health and Mentel Hygiene. Item 27 is marked other than "netural", or items 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at	Completed by	15. Decedent's Education 16a Decedent's Usual Occu	petion		16b. Kind of Bu	usiness/Industry
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an	2 should be filed with and Mentel Hygiene. is marked other than sumatic event, the h		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street				
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ore.	of He ittern		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	ace)	Date		City or Town, State
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Baltimore,	permit. Pages te Department of Hes Important: If Itam any injury or othe once.		21 Signature of Funeral Service Licensee Alyson K Taylor 22 Name and Addis	ess of Facility CT	emation	Society	of Maryland
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	₽ ≒	edical Examiner	- Bibrilar Proum	o mo			
	The law requires that the death certificate be executed ate has been signed by the attending physician end page 2 should be deteched for use as the buriel-trensit	каш	Sequentially list conditions,	<u>∞ 1 12 (C</u>			
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Вох	thet the death cert ed by the attendin deteched for use	Physician/M					
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of Vital Records,	w requires t been signe should be	D	Hyperahemia Hypera C. Diamia		24a. Was	an eutopsy	24b. Were autopsy findings
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Division	Atte	Ë	3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Could not be determined building, etc. (Seecify)			Street and Numb	er or Rural Route Number,
Ö	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Certification:	4 ☐ Homicide building, etc. (Specify)		City of 10	wii, State)	
	the Hospital hin 24 hours the Funeral I		29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the ti Check only Medical Examiner: On the basis of examination end/or investigation, in my of the basis of examination end/or investigation.				
	the H in 24 the Fi	edical	one) end manner stated.	opinion, geath occu	rrec at the time,		· ·
	Vith Vith Coa	Σ	29b. Signature and title of certifier	se number		29d. Date signed	d (Month, Day, Year)
	0,1		Elie Salameh CRENP R	119966		01/1	17/11
	3+1		30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)		~ 1 A 1		7 (1
	<u> </u>		50 W- Franklin St, Ballimore	, MD,	21201		
	State	9	31. Dete filed (Month, Day, Year) 32. Registrer's Signature	ŕ			
	Registra		JAN 25 2011 Januar S. Sares				
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland

for State Registrar 1. Decedent's N

Completed by Funeral Director

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Physician/

Funeral

Director

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ral", or items 23a or 28a-f s Examiner must be notified

"natural",

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical

Physician/

Medical Examiner

Examine

Physician/Medical

Certificate: To Be Completed by

Medical

29a. Certifier

(Check only one 29b. Signature and

31. Date filed (Mo)th, Day, Year)

JAN 25 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Medical Examiner

	Plea						k. Ensure A Health and N	_		ble. 0 4 4 0
For State Registrar		State	JI WILL	, .aa. /		tificate of l			Reg. No.	
1. Decedent's Name	e (First, Middle,	Last)						2. Date of Dea Month		3. Time of Death
Carrie				Harp	er			January		1 19:50 M
4a. Facility Name (if	not institution,	give street and n	umber)				r Location of Death		4c. County o	
6916 Nort							s Point		Balti	
5. Social Security No. 218–88–09	82	6. Sex 1 ☐ M 2 ☐ X i		yrs. last bir 34	thday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day January 2		Birthplace (State or Foreign Country) Maryland
Usual Residence of 10a. State	10b. County		10	c. City, Tow	n or Loc	cation				10d. Inside City Limits
Maryland	Balti	more		Sp	arro	ows Point				1 ☐ Yes 2 🔀 No
10e. Street and Nun	nber					10f. Zip Code			10g, Citizen of WI	
6916 Nort	h Point	Road					219		USA	nat Country.
11, Marital Status 1 □\Never Marri 3 □ Widowed		Armed		in U.S.	If	Vas Decedent of H f Yes, specify Cuba ☐ Yes 2 🔀 No	ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Black	- American Indian, , White, etc. White
(Spe	15. Deceden	t's Education	ed)	16a		lent's Usual Occup	ation during most of work	ina	16b. Kind of Bus	siness Industry
Elementary/Seco			(1-4 or 5+)		life. DO	O NOT use retired)			Comme	.+
12 years 17. Father's Name (Eirot Adiodella I	I not)			Dri	ver	40 M-11-11	o (First Add)	Carryou	IL
Michael W		•					18. Mother's Nam	_{le (First, Middle, I} Ann Harp		
19a. Informant's Na				101	a Mailin	an Andrean (Ctroat	and Number or Rura			ate Zin Codel
Joyce A.	_		ther				venue, Ba			
20a. Method of Disp 1 Durial 2 4 Donation	Cremation	3 Removal fro		cemete	ery, crem	sition (Name of natory or other place Crematory		- 1		City or Town, State
21. Signature of Fur			o W	ell			uneral Hoers Point	LUII I		
23a. Part 1. Enter to shock, or hear Immediate Cause (disease or condition resulting in death) Sequentially list conif any, leading to incluse any, leading to incluse any, leading to incluse (Disease or that initiated events resulting in death) I	nd failure. List or Final n nditions, mediate	a. A Due b. Due c.	to caused the each line.	a bonsequence	n):	er the mode of dyin		or respiratory arre	est,	Approximate Interval Between Onset and Death
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Part II. Other signif	icant condition	ns contributing to	death but n	ot resulting	in the u	nderlying cause gi	ven in Part I.			oute to the cause of death? B Probably 4 Unknown
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27. Manner of Death	-	28a. Da	te of injury	28b.	Time of	28c. Injur	y at		w injury occurred	
1 Natural 2 Accident	5 Pending Investig		onth, Day, Ye	I	injury 50	PM 1 □	? Yes 2. SoNo	Suicida	e buha	nging
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

> State Registrar

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ARTHUR C. HETSE January JR. 22° 2011 6:40 а м Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Future Care-Arnold Arnold Anne Arundel If Under 1 Year | If Under 24 Hrs Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Months Hours Min. Sept. 8, 220-14-1630 87 Mary Land Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Maryland Anne Arundel Pasadena 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ral", or items 23a o Examiner must be Completed by Funeral 2933 Golden Fleece Drive 21122 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?
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Yes 2 □ No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: "natural", 3 X Widowed 4 ☐ Divorced Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) United States Federal Govt. and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Attorney at Law Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Arthur C. Heise Ida Schmidt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Betty J. Drain (Sister) 2933 Golden Fleece Drive, Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date ☐ Burial 2 X Cremation 3 ☐ Removal from State Atlantic Crematory Jan. 24, 2011 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundamental Service License: 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 Part 1. Enter the disease, or complications that caused the death. Do not enter the manack, or heart failure. List only one cause on ach line. de of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final paje Physician/ inson disease or condition resulting in death) COM Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of) Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant a Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 W 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 24a. Was an autopsy performed? Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 E No မ 1 Inpatient 2 ER/Outpatient 3 DOA rsing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Watural injury 5 Pending 2 🗌 No Accident Investigation within 24 hours after deat To the Funeral Director: 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 200 MIV 30. Name a on who completed cause of death (Item 23a) (Type, Print) (50) bat mo . Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item I per DVR Item II per inf G912 2/4/11 dk
State of Maryland / Department of Health and Mental Hygleriek For State Registrar Certificate of Death Reg. No. edent's Name (First, Middle Last) 2. Pate of Death Physician/ Medical 0 Taniki Marie S. Johnson not institution, give street and number) Examiner 4c. County of Death 7. Age (In yrs. last birthday) 8. Date of Birth

Aug 26, 1975 Birthplace (State or Foreign Country) 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 1 M 2 F Days Hou*rs* **Director** or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director NIA 1 Yes 2 No salt mae 10e. Street and Number 10g. Citizen of What Country? Funeral 21206 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 X Never Married 2 ☐ Married 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black 3 Widowed 4 Diverged-Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be Eather's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ onnson 19a. Informant's Name/Relationship (Type, Print) City or Town, State, Zip Code 19b. Mailing Address (Street and Number or Rural-Route Number Williams Moravia 132/to MD 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Signature of Funeral Service Li 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate val Between Immediate Cause (Final and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within £2 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, No 3 ☐ Probably 4 ☐ Unknown 1 🗆 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 Other: ၉ Inpatient 2 🗆 ER/Outpatient 3 DO/ 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death 28a. Date of Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d, Describe how injury occurred Natural Accider 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Signature State JAN 25 Registrar

DHMH 17 Rev 7/2009

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ LISELOTTE MARGARETE JARUSEK JANUARY 22, _201T 3:00 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death UPPER CHESAPEAKE MEDICAL CENTER BEL AIR HARFORD If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 ☐ M 2 🗐 👍 074-26-1904 June 3, Year **Director** 1929 81 Germany Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits r 28a-f s notified 1 Yes 2 No Maryland Harford Abingdon 10e. Street and Number 10f. Zip Code must be r 10g. Citizen of What Country? Funeral 1413 Pomeroy Ave. 21009 USA Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner 14. Race - American Indian 1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No Specify: 3 Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Arthur Erich Ritter Elisabetha (nmn)Fink 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philip A. Jarusek / Son 25662 Frenchtown Road, Westover, MD 21871 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State Mt. Zion U.M.C. Cem. 1-28-2011 4 ☐ Donation 5 ☐ Other (Specify) Bel Air, Maryland 21. Signatur McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enfort he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final STrake Physician/ Onset and Death disease or condition resulting in death) Due to (or as a consequence of): Examiner stonam Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical pe Box 68760 Hospital or Attending Physician: The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Day Year Unknown 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed? Yes 2. No certificate 1 Yes 2 No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ ***Inpatient 2 - ER/Outpatient 3 - DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (| diatural 5 Pending injury Accident 1 Yes 2 No after deatl Director. Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place. 24 hours Medical 29a. Certifier completed Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the I only one) 29b. Signature and title of certifier MS 21014 (MUHAMMAD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Upper Chesifeate Dr. KHADAR 31. Date filed (Month, Day, Year) State 32. Registrar's Signature 25 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Katherine E. Jenkins Month AVUARY 2011 12:23 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SAINT JOSEPH MEDICAL CENTER BALTIMURE TOW SON Funeral Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 212-10-2753 1 M 2 X F Hours 94 Yrs. Sept. 2,1916 **Director** Baltimore, Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore Parkville 1 ☐ Yes 2X No 5 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 8820 Walther Blvd. #2114 21234 United States items death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? o 1 Never Married 2 X Married Completed by 72 hours after Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exanonee. If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry
Moore Books Publishing (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Bookkeeper Protzman Brothers Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David Conrad Chenoweth Emma Hamilton Watts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2512 Girdwood Road, Timonium, MD 21093 Nancy J. Paulis/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State contract of Disposition (varies of Competer), crematory or other place)
Dulaney Valley
Memorial Gardens 1 X Burial 2 Cremation 3 Removal from State January 4 ☐ Donation 5 ☐ Other (Specify) 2011 Timonium, Maryland 28, 21. Signature of Funeral Service License Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Physician/ CARDIAC ARRYTHMIA disease or condition HOURS Medical resulting in death) Due to (or as a consequence of): Examiner ACUTE MYOCARDIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last HOURS Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transi CORONARY ARTERY DISEASE YEARS Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy
5 Other (specify) 23d. Date of delivery Pregnant at time of death Month Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown been a 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an has autopsy performed? Yes 2 No certificate 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner?
1 \(\sum \) Yes 2 \(\sum \) No in 24 hours after deam. **he Funeral Director**: After this ce noleted filled in by the funeral dire ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 1 Natural Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work Accident Suicide Investigation M 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 2 To the F

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

State Registrar

29b. Signature and the

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7601 OSLER DRIVE TOWSON

29d. Date signed (Month, Day, Year)

2011

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D61731

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM# I per DVR, G9 I1, 1725 720 11, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Rudolph C. Johnson Sr. 2. Date of Death 3. Time of Death Physician/ I ido ph Month Yea 6:20 AM Medical 0 201 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BalTIMORE GOOD SAMARITAN HOSPITAL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth Funeral 9. Birthplace (State or Foreign M 2 DF Days Hours NOV: 15 Year 1925 219-10-0707 85 Country) Director Yrs MD Usual Residence of Decedent or 28a-f shov 10a. State 10b. County filed within 72 hours after death with the Maryland or other traumatic event, the Medical Examiner must be notified at **Funeral Director** 10c. City, Town or Location 10d. Inside City Limits MD Baltimore 1 Yes 2 ☐ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 2031 E. 32nd St. 21218 USA 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 10 þ 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify SpecifyBlack "natural", 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 hr. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medic once. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) FortMeade/Warehouseman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Thomas Johnson Elmira Blake 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Addie L. Johnson (wife) 2031 E.32nd St. Balto, Md. 21218 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State vet.cem: 4 Donation 5 Other (Specify) Garrison Forest OwingsMills,MD gnature of Funeral Service Licensee 22 Name and Address of Facility Calvin B. Scruggs 1412 E. Preston St. Funeral Home Balto,Md._21213 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ ISCHEMIC disease or condition resulting in death) ACUTE STROKE Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c, If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Unknown Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION, CONGESTIVE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? CANCER. PROSTATE 24a. Was an has autopsy performed? certificate ☐ Yes 2 No 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗹 No ၉ 1 Yes Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this I Director; After the d in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) thin 24 hours at the Funeral D mpleted filled in Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Under the date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20 xuv. M.D RES DOC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (n V 5601 LOCH RAVEN RLVD GOOD SAMARITAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 25 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 01447 Certificate of Death 2011 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Frederick Paul January 23 2011 Kress 1:00AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1812 Ellinwood Road Baltimore County Baltimore Funeral 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) August 7 1964 9. Birthplace (State or Foreign 1 🖵 M 2 🗆 F Days Min. Director 215 68 1246 46 Vrs Baltimore, Maryland Usual Residence of Decedent oortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore Baltimore County 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1812 Ellinwood Road 21237 LISA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Force Black, White, etc. Completed by I 1XX Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ☐ Yes 2 🔀 No If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Painter Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick William Kress Carleen Fischer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau Carleen F. Kress 1812 Ellinwood Road Rosedale, Md. 21237 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. January 25 2011 Baltimore, Maryland Sign sure of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home Inc 17401 Belair Road Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ End Stac disease or condition d ISEGS Medical resulting in death) Due to (or as a consequence of): Examiner Hepatins Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence or). a Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
24 hours after death.
Funeral Director. After this certificate has been signed by the attending physician and Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Dav Year signed by the a Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 ☐ Yes 2 XNo Yes 2 N completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be ဂ္ 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation Could not be Accident Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0063176 WWD. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chienyenwa Mwachinemetre.

Registrar

State

-oad

Registrar's Signature

Baltimore

Mary

Belair

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868

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Robert William Kline Jahuary 22^y 201^r1^{ar} 10:40 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Center Towson 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 214-30-5914 1**X** M 2 □ F Months Days Hours August 21 1933 Director 77 Yrs MaryTand Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Mary land Worcester Ocean City 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 105 123rd Street #119 21842 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Completed by Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 Widowed 4X Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) CityParks Department Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Jennings Kline Thelma В. Harker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ed Adams / Nephew 8 Michaela Court Parkville, Maryland 21234 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Dulaney Valley Mem. Gdns. 1/25/2011 Timonium, Maryland 4 Donation 5 Other (Specify) 21. Signature of Fungal Same Lice 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. any Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine cause. Enter Underlying Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or linjury To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran. that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Dio After this certificate has autopsy performed? Yes 2 death? ☐ Yes 1 ☐ Yes 2 ☐ No • Hospital or Attending Physician: 1 24 hours after death. • Funeral Director; After this certifica 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work ☐ Accident ☐ Suicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check To the within 2 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature ar title of cartifie 29c. License numbe 29d. Date signed (Month, Day, Year) MO D71040

State Registrar TH74

25 201

NCHARIES

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State	of Marylar					and N	1ental Hy	giene			
			Registrar	1 December 1 December								201	1	01449		
	Physicia		-	1	,							2. Date of De Month	Day		ar	3. Time of Death
	Medi Examir		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. Cou							County of D	o o th	7:39 AM				
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	Funeral	Г	5. Social Security Nur		6. Sex 1 □ M 2X F	7. Age (In yrs.	last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir	th	9.	Birthpla	ce (State or Foreign
	Director		212-36-435 Usual Residence of D		1 🗆 IVI 2 🕰 F	73	Yrs.	IVIORILIIS	Days	Hours	IVIII1.	8. Date of Bir (Month, Da Dec . 6	, 19:	37 M	lary.	Land
	and show at	5		10b. County		10c. Cit	ty, Town or Loc	cation							100	I. Inside City Limits
	Maryla 18a-f	Director	Maryland	Harfo	rd	Jop	pa									1 ☐ Yes 2 No
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	r iten	교	11. Marital Status		Armed Fo			Vas Dec e de Yes, sp e ci	ent of His fy Cubar	spanic Orig	gin? (Spe , Puerto l	cify Yes or No- Rican, etc.)		14. Race - Ai Black, W		
336	s after al", o Exam	d by	1 ☐ Never Marrie 3 ☐ Widowed 4		If Yes, Giv		1	☐ Yes 2	X No	Specify:					Whi	
21215-0036	hours natur lical I	Completed		15. Deceden	Year or Date's Education	ales.	16a. Deced	ent's Usual	Occupa	ition			16b Kir	nd of Busine		
218	iin 72 ie. han "	dwo	Elementary/Secon		t grade completed) College (1	-4 or 5+)	(Give k	ind of work NOT use	done du	uring most	of workii	ng	TOD. TO	id of Dusine.	sa muus	ou y
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Maryland	2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	To B	17. Father's Name (Fir Ernest Wi		*							(First, Middle,		iumame)		
Ž	ould by mark mark	ľ	19a. Informant's Nam				T		_			rie McK				
	i 2 shalth ar 27 is r trau		Daniel Zi			band	306 S	g Address (Sheff:	ield	nd Numbe . COU	r or Rurai	Route Numbe	r, City or T	Town, State,	Zip Cod	fe)
Jre,	ye 1 and 2 It of Health If item 2; or other t		20a. Method of Dispos				Place of Dispos	sition (Name	e of			ate		cation - City	or Towr	ı, State
<u>ii</u>	Page ment o ant: If ury or		1 🔀 Burial 2 🗆 4 🗖 Donation 5		3 🗀 Removal from ecify)	State Sp	emetery, crem esutia	etory or oth Cemet	er place cery	" []	L-28-	-11	Abeı	rdeen,	MD	
Baltimore,	permit. Page Department Important: I any injury or once.		21. Signature of Fune	Al Service D	ensel/		Mo	Name and	Address Fu	of Facility nera	Hon	e, P.A				
			23a. Part 1. Enter the	disease, or o	complications that of	aused the deat		SI/C)Kes	burv	Roac	L Abin	adon	MD 2	71/25	pproximate
	h sician/		Immediate Cause (Fir	rallure. List or	ily one cause on ea	ch line.	- 1					,	001,		In	terval Between nset and Death
	Medical		disease or condition resulting in death)		a. Due to (or as a consequ		at E	loc	-					-	
	Examiner	L	Sequentially list cond	litions	h ———										1/6	day
	od sit	nine	cause. Enter Underly Cause (Disease or iin	ediate ing	Due to (or as a consequ	rence orj.									
10	ecute and I-trans	Exar	that initiated events resulting in death) Las		c	or as a consequ	ience of:								-	
0	cate be executed physician and the burial-transit	edical Examiner	,		`											
	ficate g phys				a							 				
8	eath certific attending p d for use as	an/N	IF FEMALE: 23b. Was decedent pr			come of pregna Birth 2 Feta		Estapia pr	anana				2	3d. Date of c	delivery	
Box 687	death	Physician/M	in the past 12 mo 1 ☐ Yes 2 ☑ 1 9 ☐ Unknown	onths? No		nant at time of d		Other (spe						Month	Da	y Year
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ord	requi	Completed												>		1
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E I	an: Th tificat tor, pa		25. Was case referred	to medical	1		_		26 Plac	e of Death	Chack	1 X Yes	2 🗌 No		es 2	No
Ĭ Ĭ	nysicia iis cer direct	10 B	examiner?	No	Hospital:	npatient 2	ER/Outpatient	3 🗆 DOA	Other			ne 5 🗆 Resid	ence 6	Other (Sa	ncifu)	
o o	ng Pl	ie	27. Manner of Death	5 Pending	28a. Date o		28b. Time of injury		Injury a			Bd. Describe h			city)	
ioi i	tendi Jeath. Ior: A the fu	itics	2 Accident	Investiga	tion	= ===		М	1 🗀 Ye	es 2 🗆 I	No					
Division of Vital Records,	or Attend after death Director: A in by the fi	Certificate:	4 Homicide	determin	28e. Place	of Injury - At hor g, etc. <i>(Specify)</i>	me, farm, stree	et, factory, o	office		2	8f. Location (S City or Town		Number or F	ural Ro	ute Number,
			29a. Certifier 1	Certifying F	hysician: To the be	est of my knowle	edge, death or	cured at th	e time. d	late and n	lace, and	due to the car	ise(s) and	manner as s	tated	
-	ne Ho in 24 he Fu ipleter	Medical	(Check 2 L	Medical Exa	aminer: On the basi lurse Practioner: T	s of examination	and/or investig	ration in my	opinion	death occ	surrord at t	ha tima data ar	ad place o	and due to the	a nounal	s) and manner stated.
	lo the within 2 To the сотре		29b. Signature and title					29c. L	icense n	number		- 2		signed (Mon		
					MO			R	ES	-00	00		1/2	111		
	10		1.		no completed cause	of death (Item	23a) (Type, Pri	nt)				10.0	7			
	Stat	e	31. Date filed (Month, D	Oay, Year)	- 49 41 32. Re	gistrar's Signatu	ure Av	e 5	AC	TIME	RE	14(1)	2122	-4		
	Registra	_	MAN 25	2011	Zeneva)	gistrar's Signatu	Maria									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 _ State	artment of Health and Mental rtificate of Death	Hygiene	01450			
			Registrar 1. Decedent's Name (First, Middle, Last)	Reg. No.					
	Physicia	an/		Monti	of Death h	3. Time of Death			
	Medic Examir		Jean F. Kropp 4a. Facility Name (if not institution, give street and number)	Janu		12:15P ^M			
	Exami	iei	13322 Red Coat Lane	4b. City, Town, or Location of Death	4c. County of De				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs, last birthday)	Phoenix If Under 1 Year I If Under 24 Hrs. 8. Date of		timore Birthplace (State or Foreign			
	Director		164-20-8689 1 □ M 2 🗓 F 84 Yrs.		h, Day, Year)	PA			
	, w		Usual Residence of Decedent		11, 1720				
	yland f she	턍	10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits			
	Mar 28a	Director	MD Baltimore Phoer			1 ☐ Yes 2 💢 No			
	th the			10f. Zip Code	10g. Citizen of What	Country?			
	ms 2	Funeral	13322 Red Coat Lane	21131	USA				
	r dea or ite		Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc	No- 14. Race - Ar Black, Wi	nerican Indian, nite, etc.			
980	s afte al", c Exan	d by	1 2 100 2 31.10	1 ☐ Yes 2 💢 No Specify:		White			
Š	hours natur lical I	Completed	15. Decedent's Education 16a. Dece	dent's Usual Occupation	16b. Kind of Busines				
215	n 72 e. an "r Med	Ę	(Specify only highest grade completed) (Give Elementary/Seconday (0-12) College (1-4 or 5+)	kind of work done during most of working OO NOT use retired)	Tob. Killa of Basilles	s muustry			
21	withi giene ger th		2 Hon	emaker	Own Ho	me			
nd	filed tal Hy d oth	o Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mid	ddle, Maiden Surname)				
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	2	Eliter W. Recier	Bessie	L. Ketner				
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Ba	permi Depar Impor any ir	/ 3	Mirhael I Flagle I	2. Name and Address of Facility emmon Funeral Home of 0 W. Padonia Road Tim	Dulaney Vall	ey, Inc.			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter	U W. PAGONIA ROAD IIM er the mode of dving, such as cardiac or respirato	onium, MD 210	Approximate			
	Physician	2.	snock, or heart failure. List only one cause on each line.	3 STRUCTIVE LUNG		Interval Between			
	Medical		disease or condition resulting in death) a. Due to (or as a consequence of);	737100 1100 20100	DREUJE	YILS.			
	Examiner		CIGARETT	E SMOLING		Yns			
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	e exe	a E	resulting in death) Last Due to (or as a consequence of):						
9	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical	d						
687	ertific ding page as	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	-		1			
X	ath ce attend for us	cian	in the past 12 months?	Ectopic pregnancy Other (specify)	23d. Date of d Month	elivery Year			
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P.O. Box 687	that the	Completed by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the	inderlying cause given in Part I. 23e. I	Did tobacco use contribute	to the cause of death?			
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<u>=</u>	an: T tifica tor, p	Be C	25. Was case referred to medical	26. Place of Death (Check only one)	Yes 2 No 1 ∐ Y	es 2 No			
<u> </u>	lysici is cer direc	To B	examiner? 1	Othors	Residence 6 Other (See	oifu)			
ō	ng Pł ter th neral		27. Manner of Death 1	1	be how injury occurred	City)			
<u>o</u>	eath. or: Ai	ifica	2 Accident Investigation 3 Suicide 6 Could not be	M 1 ☐ Yes 2 ☐ No					
Division of Vital Records,	or Att	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	Lon Lordin	on (Street and Number or R Town, State)	ural Route Number,			
5									
	e cause(s) and manner as s ate and place, and due to the	cause(s) and manner stated							
	orthe orthe ompl	29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Ye							
		DZ6394 1/20/2011							
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	F \$ F 0		30. Name and address of person who completed cause of death (Item 23a) (Type, F	,,,	1 1 001	ωn			
	F \$ F O		30. Name and address of person who completed cause of death (Item 23a) (Type, F	rint)	, ,				
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 22, 12:35 P^M 2011 January Charles Edward Leake /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2403 Rockwell Avenue Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☑ M 2 ☐ F Yrs 1944 212-42-9564 5, MD **Director** 66 Oct. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show may Injury or other traumatic event, Its. Walton Evan in the multiple at any Injury or other traumatic event, Its. Walton Evan intermediate to notified at appear. 1 □ Yes 2 121 No Director MD Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21228 USA 2403 Rockwell Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ∐Yes 2 ∑No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 No Specify: ò 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Owner/Operator Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Lovell Leake Veronica Elizabeth Reynolds ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 225 Osborne Avenue; Catonsville, MD 21228 Tiffani Price Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 1/29/2011 Baltimore, MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Sign; ture of Funeral Service Licens 1630 Edmondson Avenue: Catonsville, MD 21228 23a. Part1. Enter the disease, of a mplications that caused the death. It o not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MyoloBipl INF Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 Probably 4 ☐ Unknown 1 Tes 2 🗌 No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No autopsy performe 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and Box 68760, P.0. Records, Division of Vital filled in by To the Hospital within 24 hours a To the Funeral D

1 A Natural

2 Accident

4 Homicide

29b. Signature and title of pertifier

31. Date filed (Month, Day, Year)
JAN 25 2011

IMMUND P

3 Suicide

29a. Certifier (Check only one)

5 Pending investigation

6 Could not be determined

Maryland 21215-0036

Baltimore,

DHMH 17 Rev 1/2001

Medical

State Registrar

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) In the 100 Ostmon le

32. Registrar's Signature

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D34911

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

2011

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			For State Registrar		State of M	aryland		artment of rtificate of		d Mental Hy	rgiene U	1 11406	
	Physic	ian	1. Decedent's Name (First, Middle, Last)							2. Date of De	eath	3. Time of Death	_
	/Medi		Harry Edward Lutz January 22 2011										Λ
	Exami Funeral Director		4a. Facility Name (If 5. Social Security No. 220-22-	mber 6. Se 1184	RSIDE BELCA		ELCA/ r If Under 24 F	n P Irs. 8. Date of Bir	av. Year)	f Death POR 9. Birthplace (State or Foreig Country) Maryland	gn		
	and w		Usual Residence of	Decedent 10b. County		10c. City	Town or Lo	cation				10d. Inside City Limits	_
	death with the Maryland ms 23a or 28a-f show	ţ	MD	Baltim	ore		indalk					1 ☐ Yes 2 ☐ No	
	n the	irec	10e. Street and Num					10f. Zip Code			10g. Citizen of Wh		
	th with	a D	225 Oak	wood Road	l)		2122	22		United	d States	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examirer must be rutified at once.	by Funeral Director	11. Marital Status 1 Never Marrie 3 Widowed 4		12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:			Nas Decedent of fYes, specify Cu I □Yes 2 ☑		(Specify Yes or No erto Rican, etc.)	14. Race Black, Specify:	- American Indian, White, etc. White	
5-0	72 ho natur lical J	eted	(Special	15. Decedent's Edu fy only highest grad	ication			dent's Usual Occi			16b. Kind of Busi		_
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	Hygie Hygie ther t		17. Father's Name (F	First Middle Last)			Pri	nter	40 44-4	(Cinal Middle	A. & M.	-	
au	ental ked o	o Be		arry Lutz					Mari		Maiden Surname) -		
ary	shoul and M s marl umati	ပ	19a. Informant's Nar		/pe. Print)		19b. Mailin	a Address (Stree			er, City or Town, St	tate Zin Code)	-
Z	and 2 ealth a r 27 is er tra		Carole	Anderson	/Domestic	Partne						, <u>z.</u> p eege)	
Baltimore, Maryland	Pages 1 ament of He ant: If item ury or oth		20a. Method of Dispo	sition	Removal from State	20b. Plac	ce of Dispos netery, crem	sition (Name of natory or other pla eek Cen	ace)	Date Jan 27	20c. Location - Ci	ity or Town, State	
Balt	permit. Depart Import any inj		21. Signature of Fun	eral Service Licens	Rella	0144		Nacreamath	esh ^{of} and Fi	neral Alt	ernatives	ryland 21286	
			23a. Part 1. Enter the shock, or heart	disease, or compl failure. List only or	ications that caused ne cause on each lir	I the death.	Do not ente	er the mode of dy	ing, such as card	ac or respiratory a	rrest,	Approximate Interval Between	
	Physician		Immediate Cause (F disease or condition		Cerel	mvn	ICVIA	n Ac	cident			Onset and Death	
	/Medical Examiner		resulting in death)		Due to (or as	a consequer	nce of):	• • • • • • • • • • • • • • • • • • • •	7			5	_
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4	ficate be executed physician and s the burial-transit	Examin	cause. Enter Underly Cause (Disease or in that initiated events	ring jury	1110000							1	
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	± 50 a	Mec	IF FEMALE:										
O. Box	ie death certi the attending ned for use a	Physician/M	23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☐ I 9 ☐ Unknown	onths?					cy		23d. Date of Month		
9.	that the ed by detacl	Ę.	Part II. Other signific	ant conditions cor	ntributing to death bu	ıt not resultir	na in the un	derlying cause di	ven in Part I	23e Did to	phacea use contribu	ute to the cause of death?	-
ords,	The law requires that the death cer ate has been signed by the attendir page 2 should be detached for use	sted by					ig iii tile tili	derlying cause gr	veri iii Fait I.			☐ Probably 4 Unknown	1
Division of Vital Records,	ician: The law certificate has ector, page 2 s	Completed								24a. Was a autop perfor 1 □Yes	rmed? dea	re autopsy findings available or to completion of cause of ath?]Yes 2 □ No	÷
<u> </u>	sicial certi irecto	Be	25. Was case referred examiner? 1 ☐ Yes 2 ☑ No.	Tu	lospital:			Oti		eath (Check only or			
o o	g Phy er this eral d	틸	27. Manner of Death		28a. Date of Injur	nt 2□ER ry 28	l/Outpatient b. Time of	3 DOA	4 🖎 Nursing		lence 6 Other	(Specify)	
io.	ath. r: Afte	atio	1 ☑ Natural 2 ☐ Accident	5 ☐ Pending investigation	(Month, Day	i, Year)	Injury	28c. Inju Wol M 1 [rk?]Yes 2 □ No	250. DOGGNECT	iow injury occurred		
Divis	tal or Attenors after death	Certification: To	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Str. City or Town,							Street and Number (n, State)	eet and Number or Rural Route Number, State)		
:	To the Nostral or Attending Physician: The Within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	edical	29a. Certifier 1 (Check only 2 one)	Certifying Phys Medical Examin	sician: To the best oner: On the basis of and manner sta	examination	edge, death n and/or inv	occurred at the t estigation, in my	ime, date and pla opinion, death oc	ce, and due to the curred at the time,	cause(s) and mann date and place, and	ner as stated. d due to the cause(s)	
_	Neith Com	Σ	29b. Signature and titl	e of certifier	00.0			29c. Licens	se number		29d. Date signed (A	Jonth, Day, Year)	
				16	//Win	1 m		Do	17975	·	1/24/11		
	3		30. Name and address	s of person who co	mpleted cause of de	eath (Item 23	Ba) (Type, P	rint)	01	1/ 0	1 0.	0 0 11111	
	Stat	e	31. Date filed (Month,	Day, Year)	32. Registra	r's Signature		13 // 10	Clifail	101 /16	W 171 /	M. 21014	
	Registra	.~		125 2011	5	A	-						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12:07 p ^M Richard James Lindsley 2011 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Stella Maris Hospice Baltimore Timonium 8. Date of Birth (Month, Day, Ye. If Under 1 Year If Under 24 Hrs. Social Security Number . Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days Year) 1 🔯 M 2 🗆 F Months Hours Min. Country) Director Ohio <u> 294-26-5052</u> 81 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland , or items 23a or 28a-f sho miner must be notified at Director 1 🗆 Yes 2 🔀 No Perryville Maryland Ceci. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 100 Greenway, 305 21903 Apt. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian. Examiner Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. ò 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify: White "natural" Completed 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Transport Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lena Rosella Hendrickson James Homer Lindsley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health at Important: If item 27 is any injury or other trat Carol Ann Lindsley / Wife 100 Greenway, Apt. 305, Perryville, MD 21903 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 🗀 Burial 2 🗆 Cremation 3 🗖 Removal from State 4 Donation 5 X Other (Specimentombrent Air Memorial Gdn. 1-25-11 Bel Air, Maryland Coneral Service License 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ LEUKEMIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Pregnant at time of death 5 Other (specify) 1 Lyes 2.5 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Division of Vital Records. 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy this certificate 1 Yes 2 X No 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, i 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 X Natural 5 Pending 1 🗌 Yes 2 🗆 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. JACKIE JONES, CRNP TIMONIUM, MD 21093 32. Registrar's Signature JAN 25 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

JANUARY

RICHARD LINDSLEY

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			For State Registrar	Oldio of Mic	ii y iai ie		tificate of l		_	Reg. No.		·		
Н	Physicia		1. Decedent's Name (First, Middle, Last)						2. Date of De Januar		20°1′1	3. Time of Death		
	Medic Examir		Lula Mae Littlejoh 4a. Facility Name (if not institution, give s	4b. City, Town, o	r Location of Dea		4c. County of	4c. County of Death						
		М	1520 W. North Avenu	st birthday)	Baltimo		s. 8. Date of Bir							
	Funeral Director		249–48–7597	Months Days	Hours Mir		1, Year 914 S	outr	Carolina					
	and show i at	٥	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	cation				1	10d. Inside City Limits		
	e Maryl - 28a-f notifie	Direct	MD N/A 10e. Street and Number		Bal	timore	10f. Zip Code							
	with the	Funeral Director	1520 W. North Aver	nue Apt. 3	Apt. 310			1217				ntry?		
	death items ner mu		11. Marital Status	12. Was Decedent Ev Armed Forces?	ent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe			Specify Yes or No- to Rican, etc.)						
036	ge 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ed by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give 1 Year or Dates.			☐ Yes 2 🗹 No	Specify:		Specify:				
21215-0036	72 hour n "natu fedical	Completed	15. Decedent's Edi (Specify only highest grad	e completed)		(Give k	lent's Usual Occup kind of work done (O NOT use retired)	during most of we	orking	16b. Kind of Bus	siness Inc	dustry		
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aryl	should be file and Mental I 7 is marked c raumatic eve		Jimmy Smith 19a. Informant's Name/Relationship (Type	e, Print)		19b. Mailin	g Address (Street			nber, City or Town, State, Zip Code)				
	and 2 s Health em 27		Addie Iouise Littlejchr 20a. Method of Disposition	ı – Daughter	_		Francis sition (Name of	Street E						
Baltimore,	Page 1 anent of Hant of Hant: If its		1 M Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		cei	metery, crem	natory or other place orial Par		Date 2/2011		•			
3altii	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service License			_								
	PU = # 0	-	23a. P 1. Enter th. disease, or compli	cations that caused	the death.						1 2121	Approximate		
	Physician/		ock, or heart failure. List only one Immediate Cause (Final disease or condition		rosc	Centre	e la	-d.over	ulan	direco		Onset and Death		
	Medical Examiner		resulting in death)	Due to (or as a		nce of):	1 h f		0	1:-		20 x.E		
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687	eath certificate be attending physic I for use as the b	/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome o	f pregnanc	су				23d Date	of deliv	an/		
Box 68760	The law requires that the death certificate tate has been signed by the attending physipage 2 should be detached for use as the t	Physician/Medic	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birth 2 4 Pregnant at 9 Unknown			Ectopic pregnand Other (specify)	ру ————————————————————————————————————						
P.O.	requires that the der been signed by the should be detached								23e. Did to	bacco use contrib	9. Birthplace (State or Foreign South South Carolina 10d. Inside City Limits 1 Ves 2 \(\text{No} \) Notitizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: Black Kind of Business Industry Trivate Homes or Town, State, Zip Code) aryland 21 217 Location - City or Town, State dlawn, Maryland Interval Between Onset and Death			
ds, F	quires t en sign suld be	1 Yes 2 No 3 Pr									3 🗆 Prot	bably 4 🗆 Unknown		
Scor	law rec has be je 2 sho	Completed	-						autop	autopsy prior to completion of ca				
al Re	ician: The le certificate he ector, page	Be Co	25. Was case referred to medical					ace of Death (Ch	1 ☐ Yes	2 No 1	☐ Yes	2 🗆 No		
F Vit	Physician: this certific ral director,	욘	1 L Yes 2 L No	ospital:				4 ☐ Nursing	1)		
o uc	Attending Physician: or death. ector: After this certific by the funeral director,	icate	27. Maprier of Death 1 Autural 5 Pending 2 Accident Investigation	(Month, Day, Year) injury work?				28d. Describe h	28d. Describe how injury occurred					
Division of Vital Records,	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completed filled in by the funer	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	njury - At home, farm, street, factory, office				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
Ö	the Hospital or hin 24 hours afte the Funeral Dir mpleted filled in I	Medical (29a. Certifier 1 Certifying Physic											
	the Ho thin 24 the Fu mplete	Mec	(Check 2 ☐ Medical Examine only one) 3 ☐ Certifying Nurse 29b. Signature and title of certifier	Practioner: To the b	est of my k	and/or investi knowledge, d	eath occurred at the	e time, date and p	lace, and due to the	e cause(s) and man	ner as sta	ated.		
	Not the second		29b. Signature and title of certifier \(\hat{\chi} \hat{\chi} - \hat{\chi} \)	King,	ng			D 3 1 8		i /	ישניים וויים	/ //		
	10)		30. Name and address of person who cou	mpleted cause of de	ath (Item 2	3a) (Type, Pi	rint)	L	Balt		~			
	Stat		31. Date filed (Month, Day, Year)	32. Registrer	's Signatui	e Ked	V. THA		1) 2001	in a	-12	121		
	Registra	ar	JAN 25 2011 De	mun p.	1914									

Nery Luis Tirado 11-00442 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Tirado Luis Physician/ Nery Month Day January 15, 2011 2152 hrs **Medical Examiner** radio 1951111 c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Hyattsville 1801 Metzerott Road 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Months Hours Min Days Director Country) 1 X M 2 F Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No rince (oeorge Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code anawha Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 Married Yes 2 X No 1 Yes 2 No specify: (ovate If Yes, Give Year Divorced Banic ğ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Meat CUI 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ent of Health and Mint: If item 27 is mare reatments 05 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition san Juan crematory or other place) Burial 2 Cremation 3 Removal from State mportant: luar Donation 5 Other Specify Signature of Funeral Service License Kennedu DW Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit Physician/Medical x AMENDED 1 per me g912 2-24-11 vt attending physician for use as the burial -UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery Was decedent pregnant in the 3 Ectopic pregnancy Year Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Š 1 Yes 2 V No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available After this certificate has been 24a. Was an prior to completion of cause of autopsy the Hospital or Attending Physician: The law thin 24 hours after death. performed death? 1 🗸 Yes ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 🗸 Other: Scene 2 ER/Outpatient 3 DOA 1 🗸 Yes 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury Jan 15, 2011 Pedestrian struck by vehicle 2139 hrs Pending 1 Yes 2 ✔ No within 24 hours after death To the Funeral Director: the 2 Accident Investigation filled in by 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) 1801 Metzerott Road, Hyattsville, MD determined (Specify) Local Street Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 16, 2011 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner

UHIVIT 17 Rev 1/2001

State

Registrar

Donna M. Vincenti, MD

5

COME

ORIGINAL

strar's Signature

900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY 2011 08:55P M LEVI ARI Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A SINAI HOSPITAL BALTIMORE Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 X M 2 □ F 0672871918 92 Yrs **GERMANY** Director 214-14-2202 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at rector 1 X Yes 2 □ No MD BALTIMORE N/A ۵ 10f. Zip Code ò 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a 2502 KEN OAK ROAD 21215 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 0 þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🛚 No Specify: If Yes, Give Year or Dates "natural", Completed 3 Divorced 4 Divorced WHITE Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 PRINTING COMPUTER MACHINIST NEWS AMERICAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file.
Department of Health and Mental h.
Important: If item 27 is marked any injury or are. and Mental F ည MICHAEL LEVI TELZ ZELIGMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLOTTE LEVI / WIFE KEN OAK ROAD, BALTIMORE, MD 21215 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) AHAVAS CHESED 01/23/2011 RANDALLSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. of Funeral Service Lic. REISTERSTOWN ROAD, PIKESVILLE, MD 21208 8900 23a. Part 1. Enter the disease, or complicators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one covise on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) (or as | conseq Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or a consequence of) and -transit Exami the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last burialphysician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Line of death 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year signed by the a Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but/not resulting in the unperlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed After this certificate 2 No 1 🗌 Yes 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 📝 No 잍 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manne f Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending s after death. 1 🗌 Yes 2 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

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	State of Maryland / Department of Health and Mental Hygiene Certificate of Death State Certificate of Death Beg No.												145/						
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Maryland	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Merital Hygiene. It marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/R	Relationship (Type	, Print)				(Street a			Route Number	er, City o						
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Baltimore,	更有任务。		4 Donation 5 Other (Specify) OHEB SHALOM MEM. PARK 01/23/2011 REISTERSTOWN, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC.																
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المبدو	Examiner				Due to (or as	a conseque	erice oi).												
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Box 68760	eath certificate be attending physici for use as the bu	cian,	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) Month								Year								
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ΨŽ	nding Physician: 1 tth. : After this certifica e funeral director, p	은	1 Yes 2 No	Ho	spital: 1 Inpat 28a. Date of inju	_	ER/Outpatien 28b. Time of		Othe Bc. Injury	_ 4 ∐ Nur				6 Other (S	pecify)				
o uc	nding ath. r: After e fune	icate		Pending Investigation	(Month, Da		injury	M 20	work'			od. Describe	now inju	ry occurred					
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Inector father this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Certificate:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, far building, etc. (Specify)											Rural Route	Number,				
۵	To the Hospital or vivitin 24 hours after To the Funeral Directory		29a. Certifier 1 💢 C	Certifying Physici	an: To the best of	mv knowle	edge, death o	ccured at t	he time.	date and p	lace, and	due to the ca	ause(s) a	ind manner as	stated.				
	he Ho in 24 h he Fur	Medical	(Check 2 M	ledical Examine	r: On the basis of e Practioner: To the	xamination	and/or invest	gation, in m	ny opinio	n, death occ	curred at	the time, date	and place	e, and due to t	he cause(s) a	nd manner stated			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 91458 State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** arrie 1033 A M 2011 January /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Mercy Medical timore Baltimore 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/10/1949 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** North Carolina 1 □ M 2**XX**F Months Days Hours 218-58-9137 61 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits r items 23a or 28a-f show ther must be notified at 10a. State Director 1X Yes 2 □ No N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 1 Conway Street 21201 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 \(\text{Yes} \) 2 \(\text{X} \) No Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 ō If Yes, Give Year or Dates: 1 ☐ Yes 2 No American þ Specify: Specify: 3 XWidowed 4 ☐ Divorced Indian Completed traumatic event, I'm Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Franklin Chavis Margie Rea Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I Mac Arthur Chavis - Brother 1707 Boggs Road Forest Hill, Maryland 21050 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 0 Department of Important: If it any injury or oonce. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 01/22/2011 Baltimore, Maryland 22. Name and Address of Facility
David J. Weber Funeral Homes P.A.
401 S. Chester Street Baltimore, Maryland 21231 21. Signature of Funeral Service Licensee 23a. Part I. Enter the disease of shock, or heart failure. ist o ly implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final pertension **Physician** disease or condition resulting in death) 18ars /Medical Due to (or as a c insequence of): Examiner abete Ears Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exami as the burial-transi and Due to (or as a consequence of) Box 68760, attending physician Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy for Month Dav Year 5 ☐ Other (specify) P.0. ned by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 2 No 1 □Yes 1 ☐ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 Inpatient 2 KER/Outpatient 3 □ DOA Certification: To After this I Director: After this od in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 24 hours after Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D. 0 55662 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD Mas tellone 301 St. Paul Place Jusan 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 25 2011 Registrar

State of Maryland / Department of Health and Mental Hygiene? For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mon Physician/ 1057M la 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Seasons Hospice at Northwest Hospita Randallstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🛛 M 2 🗆 F 08/11/1945 Director 213-48-2798 Tennessee 65 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Catonsville 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21228 401 Beechwood Avenue 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2XX No If Yes, Give 1 Yes 2 X No Specify: "natural", Specify: White 3X Widowed 4 ☐ Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) +12 Physician Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 7 is marked o ဂ္ Albert Peck Little Julia West 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 16425 Equestrian Lane Rockville, Maryland 20855 Julie Cunningham - Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Crestlawn Cemetery 01/25/2011 Marriottsville, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Funeral Homes P.A. Avenue Baltimore, Maryland 21229 Weber Enter the disease, or cock, or heart failure. List only in plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Exami that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death Yes 2 No detached 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by be Physician: The law requires Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perfor Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred the Hospital or Attending Natural Accident 5 Pending Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined To the Hospital within 24 hours a To the Funeral C Medical 👺 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) who completed cause of death (Item 23a) (Type, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

5-0036

Baltimore, Maryland 2121

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
mend #30 Per DVR G911 1/25/2011 JH
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 23/2011 Betty C. Mentis 6:10 AM Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carrol1 Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) Days 1 🗆 M 2 🔀 F Months Hours Min. Month, Day, Year) 6/22/1922 Director 216-16-3858 Vrs 88 MD Usual Residence of Decedent Show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Frederick 1 Yes 2 X No Walkersville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8424 Water Street Rd. 21793 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give þ 1 X Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Agent Erbe & Mentis Assoc. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Peter George Mentis Angela Faila 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Connie D. Bauer/Niece 8424 Water Street Rd., Walkersville, MD 21793 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🖾 Burial 2 🗆 Cremation 3 🗀 Removal from State Holy Redeemer Cem. 4 ☐ Donation 5 ☐ Other (Specify) 1/28/2011 Baltimore, MD 21. Signati f Funeral Service Lic Burrier Queen Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 Enter the disease, or complications to or heart failure. List only one cause caused the death. Do not enter the mode of dying, su Approximate shock Interval Retween Immediate Cause (Final Physician/ Onset and Death 1 Le certe e or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed g physician and is the burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy signed by the atte in the past 12 months? Pregnant at time of death Month Day Yes 2 No g Unknown Unknown litions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 R Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy hours after death. Ineral Director: After this certificate performed Yes 2 No 2 No Hospital or Attending Physician: filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) NPAILER Hospital: 2 No 1 Yes Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work Accident Suicide Investigation 1 Yes 2 No Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 Certifying Nurse 29b. Signature a ditle of certifier 29c. License number 29d. Date signed (Morth, Day, Year) 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Flavio Kruter 555 South Center St. Westminster, MD 21157 31. Date filed (Month, Day, Year)

JAN 25 2011 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Kobert Mitchell 619 6 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shock Trauma Baltimore NIA OF MD 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1**X**M 2 □ F Months Days Min. 576/1937 73 216-34-1570 Director Usual Residence of Decedent 28a-f shov 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Examiner must be notified at Director 1 Yes 2 K No MD Carroll Westminster ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral USA 149 Bertie Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ٥, 1 Never Married 2 XMarried ģ 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates. Unknown 1 ☐ Yes 2X☐ No Specify: Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) permit, Page 1 and 2 should be filed wit. Department of Health and Mental Hygier Important: If item 27 is marked other t. any injury or other traumatic event, the once. Tool Dye Maker C.R. Daniels Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည William Mitchell Mary Margaret Bahr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 149 Bertie Ave., Westminster, MD 21157 Mary Ellen Mitchell/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2XXCremation 3 Removal from State Carroll Crematory 1/25/2011 Winfield, MD 4 ☐ Ponation 5 ☐ Other (Specify) 21. Signa of Funeral Service License 22Burrade Guerny Funeral Home & Crematory, P.A. Think. 1212 W. Old Liberty Rd., Winfield, MD 21784 23a. Par 1. Ent a the disease, or complications that show, or hand failure. List only one cause on each line. the death. Do not enter the mode of dying, such as cardiac or respiratory west, Immediate us (Final disease or condition Onset and Death Physician/ 4-C5 Subjuxation Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter underlying or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 disease rangina, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Mostate Surger-24a Was an autopsy perform 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1
Natural 5 \square Pending work? 1 ☐ Yes 2 💢 No 22/2011 2 Accident 0 00 AM Investigation Director: 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City of Town, State) determined ome westminster mo To the Hospital within 24 hours a To the Funeral D Medical 1 Secritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Sig d title of certifier 29c. License number 29d. Date signed (Month. Day, Year) ellow ١١ ص ess of person who completed cause of death (Item 23a) (Type, Print) St Baltimore MD 21201 32. Registrar's State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1462 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Merryman Lyman Month Medical January 2011 3:20 A M 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 502 Riverside Drive Baltimore Essex 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Yea Sept. 17 9. Birthplace (State or Foreign Months Days Min 1 DM 2 🗆 Hours Director 216-24-086 Yrs. 81 1929 MD Usual Residence of Decedent show 10b. County filed within 72 hours after death with the Maryland 10a. State 10c. City. Town or Location Director 10d. Inside City Limits must be notified or 28a-f MD Baltimore Essex 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 502 Riverside Drive 21221 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner Race - American Indian Armed Forces?
1

Yes 2 □ No . 01 Black, White, etc. 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 "natural", If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) ed other than " ith and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Truck DRiver 12th Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည AlbertMerryman Mildred Perkins other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Page 1 and 2: Doreen Mitcham /daughter 5 Bangert Ave. White Marsh MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ō <u>=</u> ₀ 1 Burial 2 X Cremation 3 Removal from State permit. Page Department of Important: If any injury or Bayview Crematory 1/24/11 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signature of Funeral Service License Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) (ancer Lung Medical Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events.) Examine Due to (or as a consequence of): signed by the attending physician and de detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): cal Division of Vital Records, P.O. Box 68760 Physician/Medi IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav 5 Other (specify) Year Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy performed? Yes 2 No page certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? 1 Tes 2 No ဂ္ဂ Other: this 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury_at 28d. Describe how injury occurred 1 Natural 5 Pending Accident work? 1 ☐ Yes 2 ☐ No after deatl Director: Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0057465 DSRajupahreM.D 20/11

State Registrar

DHMH 17 Rev 7/2009

2835 Smith Av-

Varka

32. Registrar's Signa

5-203, Baltimore, MD, 21209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N.S. Rajapakt, M.D

31. Date filed (Month, Day, Year,

JAN 25 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State Registrar	partment of Health and Mertificate of Death	Re	g. No.	01463						
	Physic		1. Decedent's Name (First, Middle, Last) Robert Merenda		2. Date of Death Jan.	2% 2011	3. Time of Death 10:40p M						
	/Medi Exami		4a. Facility Name (If not institution, give street and number) Manor Care	4b. City, Town, or Location of Death Catonsville		4c. County of Death Baltimore							
	Funeral Director		5. Social Security Number 190-14-6571 6. Sex 1 → M 2 → F 7. Age (In yrs. last birthda Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, June 29,	9. Birthp 1924 Hazel	ace (State or Foreign try) Con, PA						
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or			10	0d. Inside City Limits 1						
	h with the 23a or 28a	Funeral Director	10e. Street and Number 2000 Harman Avenue	10f. Zip Code 21230		ng. Citizen of What Coun	*						
9600	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Walcel Exprine Linust to notified at	þ	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 12 Yes 2 No 17 Yes, Give 18 Yes or Dates;		ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e Specify: Whi	tc.						
Maryland 21215-0036		Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 16a. Dec (Gin life) In/a	edent's Usual Occupation e kind of work done during most of workil DO NOT use retired) Maintenance	ng 1	6b. Kind of Business/Ind							
yland	2 should be filed v n and Mental Hygir is marked other raumatic event, the	To Be C	17. Father's Name (First, Middle, Last) Joseph Merenda	18. Mother's Name Unknown	(First, Middle, Ma								
	7 = 7 +		George Beeman / Friend 1013	ling Address (Street and Number or Rura B. Haverhill Road Ba	ltimore,	MD 21229							
Baltimore,	Pages ent of it: If it y or o		4□Donation 5□Other (Specify) Crownsv	ins ^{ry} Cemetery (Jan. Jan.	25,2011	Oc. Location - City or Tov	, MD						
Ba	permit, F Departm Importar any injur		eral Home, utus, MD 21	227									
	Physician Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition resulting in death) Due to (or as a consequence of):										
0,	icate be executed by physician and physician and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate carts. Find Indexing Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):										
.O. Box 68760,	the death certif by the attending ached for use as	Physician/Medical		□ Ectopic pregnancy □ Other (specify)		23d. Date of deliver	y Day Year						
ords, P.	w requires that s been signed k should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to the	1						
of Vital Records,	sician: The law re certificate has be rector, page 2 sho	e Completed	25. Was case referred to medical	26. Place of Death		prior to com death? 1 Yes	sy findings available pletion of cause of 2 □No						
Division of V	ending Physath.	Certification: To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be	nt 3 DOA Other: 4 Nursing Hon of 28c. Injury at Work? M 1 Yes 2 No	,	ce 6 ☐ Other (Specify)						
É	oital or Attendurs after death aral Director:		4 ☐ Homicide determined 28e. Place of Injury - At nome, farm, st building, etc. (Specify)	(1)	City or Town,	·	,						
	To the Hospital or Atte within 24 hours after de To the Funeral Direct completely filled in by th	Medical	29a. Certifier (Check only one) 1 ★ Certifying Physician: To the best of my knowledge, dea 2 ★ Medical Examiner: On the basis of examination and/or i and manner stated.	nvestigation, in my opinion, death occurre	ed at the time, date	e and place, and due to	the cause(s)						
	Viti To COr		Mo Mo	D0069314		Date signed (Month, D							
	641			than Wows Rd.	Parker	ille MD	21234						
	Stat Registra	_	31. Date filed (Month, Day, Year) JAN 2 5 2011 32. Registrar's Signature	Kel									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month January 21, Year 20 2:00 PM Marcelino Montalvo-Galindo Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center for Hospice Care Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Months Month, Day Year) 1948 62 Director 584-36-6564 Puerto Rico Usual Residence of Decedent show 10a. State 10b. County death with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f (Baltimore Essex 1 Yes 2 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 1051 Foxchase Lane 21221 United States tems 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. 0 1 Never Married 2 Married should be filed within 72 hours after þ Baltimore, Maryland 21215-0036 1 Sees 2 No Specify: Puerto Rican If Yes, Give Year or Dates marked other than "natural", 3 - Widowed 4 - Divorced Specify: Completed Hispanic other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Nurse Health Care Facility Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Marcelino Maontalvo Santos Galindo and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sł ment of Health a tant: If item 27 is Mariluz Seda /Wife 1051 Foxchase Lane Essex, MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Jan 22 injury or c cemetery, crematory or other place) mportant; If 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Beltsville, Maryland 2011 M01443 21. Signature of Funeral Service Licensee 22. Name and Address of Facility

Cremation and Funeral Alternatives any 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ areut 2/0/19 Discord TOK Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to for as a ponse unner of if any, leading to immedi cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last the burial-tran signed by the attending physician and the Hospital or Attending Physician; The law requires that the death certificate be exec Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Year Dav Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has 2 No 1 Yes 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2X No Other 2 ER/Outpatient 3 DOA 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 No Accident 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after deat To the Funeral Director completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day Year) R125808 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 701 410

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink Fraure All Copies Are Legible. amend #19a Per FH G9137017011 The Certificate of Death

Reg. No. For State Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 201 Irene Morman 10:30 4-M Medical Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GE OFGESHOS PITGL CENTER DIZINCE S BOISBS CH EUE 124 V Social Security Number 6. Sex If Under 1 Year I If Under 24 Hrs. 7, Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 DM 2 Z Hours Country) Virginia 0 139-20-4414 0 ADTIT 1920 Director Usual Residence of Decedent 28a-f show 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD District Heights Prince Georges 1 Yes 2 X No 6820 Amber 10f. Zip Code 10g, Citizen of What Country? Funeral Amber Hill Court 20747 United States death \ 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 Ã No Specify. Specify: Black Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Nurse's Aide Hospitals æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Julia Tynes John W. Riggins Grace Biggins (daug 1 abalysing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (daughter) 929 Amber Hill Ct. District Heights, MD 20747 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Jan. Date 28. 1X Burial 2 Cremation 3 Removal from State Rosedale Cemetery 2011 Orange, New Jersey 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Woody Home for Services M00982 163 Oakwood Ave. Orange, New Jersey 07050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ONEUMONIA ₽nysician/ disease or condition Medical resulting in death) to (or as a consequence of) Examiner MONAIL Sequentially list conditions, it any leading to in reduce cause. Enter Underlying Examiner the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) a ending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a lending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 menths?
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3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 DHUE HOS DITTL 2. Registrar's Signatur State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-00457 Florence McNeill State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No Physician/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Day January 16, 2011 Medical Examine 1150 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2704 Beryl Avenue Baltimore 5. Social Security Number 6. Sex If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year Director Months Hours Min 1 M 2 🔀 F Usual Residence of Decedent 10a State 10b Count 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10e. Street and Number 10g. Citizen of What Country? Funeral Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Race - American Indian, Black, White, etc. 1 Never Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 Yes No specify: 3 Widowed 4 Divorced If Yes, Give Year ģ or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b Kind of Busin Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) is marked other than a Baltimore. MD 21215-0036 of Health and Mental Hygiene. 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street 20b. Place of Disposition (Name of cemetery 20c. Location tant: If it Cremation 3 Removal from State crematory or other place) 2 Donation 5 Other Specify: Signature of Fune al Sen ce Licensee 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode **Physician** failure. List only one cause on each line /Medical Between Onset and a. Metabolic Ketoacidosis Immediate Cause (Final disease Death aminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical ned by the attending physician detached for use as the burial -UNPENDED **AMENDED** the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 23e. Did tobacco use contribute to the cause of death? é 1 Yes 2 No 3 Probably 4 ✓ Unknown page 2 should be Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has performed? death? certificate ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) director, Be Hospital: 1 Other₄ this Inpatient ER/Outpatient 3 Nursing Home 5 Residence 6 ✔ Other: Scene 1 V Yes 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 V Natural Pending 1 Yes 2 No To the Funeral Director: completely filled in by the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Sa 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier

5 Day Registrar DHMH 17 Rev 1/2001

State

OCME 2006

Carol Allan, MD

30. Name and address of person who completed cause of death (Item 23a)

de

32. Registrar's Signature

Assistant Medical Examiner

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

January 17, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 17 per th 2911 1-25-11 vt State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Bessie R. Malone Jan. 20 I 18 12:00 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimore The Maples Towson 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛣 F Days Hours Min. April 20,1910 Director 100 220-20-6906 Usual Residence of Decedent 28a-f shov 10a. State 10b. County notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore Towson 1 Yes 2 No P 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be Funeral 21204 7925 York Road items 23a USA hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3√ Widowed 4 ☐ Divorced Completed Specify: Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. Do NOT use retired)
Program Operations 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mea any injury or other traumatic event, the Mea once. Elementary/Seconday (0-12) College (1-4 or 5+) Social Security Be 17. Father's Name (Eirst, Middle, Last) **Benjamin Rose** 18. Mother's Name (First, Middle, Maiden Surname) Informant Laura Zeirkler Unknown by 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Malone Cohen 7 Fieldspring Court Lutherville, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Mt.Olive Cemetery 01/22/2011 Randallstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer 22. Name and Address of Facility Home of Dulaney Valley, Inc. chae P Mi West Padonia Road Timonium, Maryland 21093 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final -Physician/ Onset and Death Men disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner several years Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Several years To the Hospital or Attending Physician: The law requires that the death certificate be executed upertension the burial-tran and Due to (or as a consequence of resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 221/2 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ours after death.

eral Director: After this certificate has filled in by the funeral director, page 2 s performed Yes 2 No 1 Yes 2 No 25. Was case referred to medical B 26. Place of Death (Check only one) examiner? Hospital Other: |은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 K Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred iniury Natural Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number DO061485 an 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Bushra I. AL-Azzawi MD, 9103 Franklin Sq. Dr Suite 301, Rosedal, MD 21237 31. Date filed (Month, Day, Year)

JAN 2 5 2011 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗇 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jan 21 Day 2011 Year Mary Elizabeth Magee 2:58 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Towson Gilchrist Baltimore Social Security Numbe Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Month, Day, Ye 1 □ M 2 😾 F Days Hours Min Director 020-14-4818 98 Country) MA June Usual Residence of Decedent 28a-f shov 10a. State 10b. County filed within 72 hours after death with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Woodstock MD 1 Yes 2 No or. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21163 10332 Old Frederick Rd. USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc o. δ 1 Never Married 2 Married ☐ Yes 2 🔀 No Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: white If Yes, Give "natural" Completed 3 → Widowed 4 □ Divorced Specify Year or Dates the Medical Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

16a. 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than 'ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Banking Banker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elizabeth Allison William A. Brunswick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 10332 Old Frederick Rd., Woodstock, MD 21163 Edward Ross/great-nephew Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 1/24/11 Atlantic Crematory Signature of Fundamental Service License 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Rd., Timonium, MD 21093 Michael 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Advance disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlyin Cause (Disease or iinjury Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed? Director: After this certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending Investigation 6 Could not be Accident filled in by the 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Dire Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of centifier 29c. License number 29d. Date signed (Month, Day, Year, 71040 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARATHI 6701 NCHARIES · SUTLE RTREET 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Joseph Anthor	ıy M	1- For State	ole ink. Ensure All Copi nt of Health and Mental H te of Death	lygiene	2011	0146
Physic Medical Exan		Decedent's Name (First, Middle, Last) Joseph Anthony Moor	io or bodin	Reg. 2. Date of Death Month Danuary 19,	Day Year	3. Time of Death 1535 hrs
` <u> </u>		4a. Facility Name (if not institution, give street and number) RDute 22 at westbound Post Road	4b. City, Town, or Location of Death Aberdeen	1	4c. County of Death Harford	
Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Yrs. If Under 1 Year If Under 24Hr Months Days Hours Mir		MM/DD/YYYY) 9. Birt Foreig 9 , 1979 Cou	
Maryland 28a-f show any d at once.	ğ	10a. State 10b. County 10c. City, Town or				10d. Inside City Limits 1 Yes 2 No
r death with the Maryland or items 23a or 28a-f sho must be notified at once.	al Director		10f. Zip Code 21078	Ur	Citizen of What Coun	es
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	by Funeral	3 Widowed 4 Divorced If Yes, Give Year	3. Was Decedent of Hispanic Origin? (Silf Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No specify:	oecify Yes or No- Rican, etc.)	14. Race - Americ White, etc.	
215-0036 be filed within 72 hours after and Hygoren and Hygoren (sed other than "natural", ent, the Medical Examiner	Completed b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	cedent's Usual Dccupation (Give kind of ring most of working life. DO NOT use retimber	red)	Sb. Kind of Business/Ir	dustry
MD 21215-0036 d 2 should be filed within 7 lith and Mental Hygiens n 27 is marked other than umatic event, the Medica		17. Father's Name (First, Middle, Last) Harry F. Moor	18.Mother's Name Mary T.	(First, Middle, Maid Kurek	den Surname)	
e, MD 2 1 and 2 shoul Health and M item 27 is m	To	Mrs. Mary Moor (Mother) 410 20a. Method of Disposition 20b. Place of D	Mailing Address (Street and Number or F 7 McNabb Road, Whit Disposition (Name of cemetery,	eford, M		
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 injury or other traus		4 Donation 5 Other Specify: Evans 1	or other place) Funeral Chapel 1/2 22. Name and Address of Facility Evans Funeral Chape		Forest Hil	
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Sion ttend death. ctor: y the f	Certification:	1 Natural 5 Pending Investigation 2 ✓ Accident 3 Suicide 6 Could not be determined 150 Major Road / Highway 150 Natural 28e. Place of Injury - At home, farm, (Specify) Major Road / Highway 150 Natural 28e. Place of Injury - At home, farm, (Specify) Major Road / Highway 150 Natural 28e. Place of Injury - At home, farm, (Specify) Major Road / Highway 150 Natural 29e.	street, factory, office building, etc.	28f. Location (Stree or Town, State)	ntrol of vehicle ar	Route Number, City
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical Ce	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or invessional manner stated.	occurred at the time, date and place, and o	due to the cause(s)	and manner as stated.	
	Ž	29b. Signature and title of certifier.	29c. License number O.C.M.E.		d. Date signed (Month	, Day, Year)
100		Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD	OW. Baltimore Street, Baltimore	e, MD 21223		
St Regist	ate rar	31. Date filed (Month Dan Year) 32. Registrar's Signature	p.			

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ebra Carol Michaelides	State of Maryland / Department of Health and Mental Hygiene	
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		1- For State Registrar		C	ertifica	ite of	Death			1	Reg. No.		
Physici Medical Exam	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Delver Classes Middle,Last							3. Time of Death 1158 hrs					
		4a. Facility Name (if not institute 8826 Baker Avenue	on, give street and				o. City, Town, o Parkville	City, Town, or Location of Death Parkville			4c. County of Baltimor		
Funeral Director		5. Social Security Number 213-74-8112	6. Sex	7. Age (in yr	s. last birth	day) Yrs.	If Under 1 Year Months Day	_			Birth (MM/DD/YYYY L 8,1955	Foreign	nplace (State of Baltimor ^{Intry)} MD
Maryland 28a-f show any d at once,	o.	Usual Residence of Decedent 10a. State 10b. County MD Ba1	timore	10c. C	ity, Town o	r Locatio	n :						10d. Inside City Limits 1 Yes 2 No
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₽ . ₽	by Funera	3 Widowed 4 Div	Armed 1 Yes vorced If Yes, Give Y or Dates:			If Yes	Decedent of His, specify Cuba	n, Mexican, specify:	Puerto Ri	can, etc.)	White	, etc. Whit	
JIMOFE, MD 21215-0036 Pages I and 2 should be filed within 72 hours a ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natura or other traumatic event, the Medical Examin	Completed	15. Decedent's Education (Spe Elementary/Secondary (0-12) 1 2	College	ade completed) (1-4 or 5+)		uring mos	s Usual Occupa st of working life Orist	o. DO NOT i	use retired)	16b. Kind of Bus		dustry
21215-0036 buld be filed within 7 Mental Hygiene. I marked other than ic event, the Medica	BB	17. Father's Name (First, Middle, Gus Michaeli	des					The	elma 1	Lee Ma	-		
MD 2 nd 2 should alth and M om 27 is on raumatic or	٩	19a. Informant's Name/Relations Donna Katun 20a. Method of Disposition			1	14 E	nglish	Run	Circ.	le, Sp	mber, City or Town Darks, MD	211	52
Baltimore, MD 2 permit Pages I and 2 shoul Department of Health and Iv Important: If item 27 is m injury or other traumatic.		1 Burial 2 K Cremation 4 Donation 5 Other Sa	pecify:	from State	evany.	FUP 1– E	Bel Air		Janua 26,	2011	Forest	Hil	1, MD
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8760, ifficate be exec in physician are the burial - to	n/Medical	UNPENDED IF FEMALE:	AMENDED	outcome of pre	egnancy						23d. Date of d	leliven	
on of Vital Records, P.O. Box 68760, rading Pbysician: The law requires that the death certificate be executed arth. After this certificate has been signed by the attending physician and he funeral director, page 2 should be detached for use as the burial - transi	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Vulk	1 Live	birth nant at time of	2	_	death 3 r (Specify)	Ectopic	pregnancy		Month	Da	y Year
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To the Howithin 24 h	Medical	(Check only one) 2 Medical Exar	nysician: To the be miner: On the basis and manner	of examination			ı, in my opinion	death occu			and place, and due	to the	cause(s)
	2	29b. Signature and title of certified					29c. License O.C.				January 23,		ı, Day, Year)
JV			istant Medical	Examiner	900 W.	Baltim	ore Street,	Baltimore	e, MD 2	1223			
Sta Regist	ate rar	31. Date filed (Month, Day, Year) JAN 25 201	1 Server	egistrar's Signa	ture	ul 0"	<u>,</u>						
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			State of Maryland / Department of Health and Mental Hygiene
		_	Tegestrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death
	Physicia Medic	cal	Robert E MONGAN Month Day Year 1:00 An
4	Examir	ner	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALT I MO 125
	Funeral Director		5. Social Security Number 213-34-8380 6. Sex 1 7. Age (In yrs. last birthday) 1 1 1 1 1 1 1 1 1
	yland -f show ed at	ctor	Usual Residence of Decedent 10a. State
	n the Ma a or 28a be notifi	Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	eath with	uner	11500 Glen Arm Road 21057 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian,
9800	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The fact and Mental Hygiene. The marked other than "hatural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Specify: White
Maryland 21215-0036	iin 72 hou ie. han "natu e Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Local Union 24
d 21	ed with Hygier other t ent, th	Be	12 Electrician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
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	and 2 sho Health an tem 27 is ther trau		Jacqueline Mongan/ Wife 11500 Glen Arm Road, Glen Arm, Maryland 21057
Baltimore,	e ± t e		20a. Method of Disposition 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of Date Date January Waller, crematory of other place) Memorial Gardens 20c. Location - City or Town, State January Timonium, Maryland
Balt	permit. Page Department Important: I any injury o		21. Signature of Funeral Service Licenses (Licenses Licenses Licenses Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234
,	hysician/ Medical Examiner	şr.	28a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Impediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death Onset
	s be executed sician and surial-transit	ical Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Asbest for Single Consequence of Conseque
. Box 6876(To the pospital of Atendang Priysican: The law requires that the death certificate with the house after death. To the Funeral Birector: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown 23d. Date of delivery 23d. Date of deliv
ls, P.O	v requires that to been signed by should be deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Whinow
Division of Vital Records, P.O.	'sician: The law req s certificate has beel lirector, page 2 shou	Completed by	RIGHT HETART FAILLIRE 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
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on of	ath. r: After the	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year) 28b. Time of injury work? 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurred
Divisi	tal or Aug		3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	ore nospinal or Australing Prysician: within 24 hours after death. To the Funeral Directors After this certific completed filled in by the funeral director,	Medical	29a. Certifier (Check only one) 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 **Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	with Son 1		29b. Signature and title of certifier Discussion MD 29c. License number 29d. Date signed (Month, Day, Year) Tan 24 3011
	14x		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAYID BORSMA 7505 OSLER DR TOWSON MD 2120
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature
DHM	H 17 Rev 7/20		JAN 25 2011 Send B. Janes

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Wendell Fulton MacIntosh 2:08 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Ba Center Medi OWSON Itimore 9. Birthplace (State or Foreign Country) Truro
Nova Scotta, CAN. **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1 **M** M 2 □ F Months Min. Director 217-26-0322 Hours (Month, Usual Residence of Decedent show 10a. State 10b. County notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f 1 🗆 Yes 2 🏝 No Maryland Baltimore County Towson 10e. Street and Number Hygiene. other than "natural", or items 23a or rent, the Medical Examiner must be r 10f. Zip Code 10g. Citizen of What Country? Funeral 1010 Winsford Road 21204-2752 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) **N/A** Elementary/Seconday (0-12) 1 and 2 should be filed with if Health and Mental Hygien item 27 is marked other the Salesman Whiskey Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Stanley MacIntosh Minnie Blanche Renouf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Mirriam (nee Woodruff)MacIntosh 1010 Winsford Road Towson, Maryland 21204-2752 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other t injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Location - City or Town, State (Harford County) 1 Burial 2 Cremation 3 Removal from State Evans Fureral Changel and Cremation Services, Inc. Thursday 4 ☐ Donation 5 ☐ Other (Specify) Jan. 27, 2011 Forest Hill, Maryland 21. Signature of Funeral Service Licensee Jeffrey L.Gair, Sr. Penceful Alternatives Funeral & Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093-2215 Lic.#M00677 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Mynca disease or condition Medical resulting in death) Examiner oronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of death certificate be executed Cause (Disease or linjury -tran Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death signed by the a Unknown g 🗌 Unknown Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Chronic Kidney Disease Stage 4 Division of Vital Records, No 3 ☐ Probably 4 ☐ Unknown Completed 1 Tes Diabetes Mellitus Type II 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy perform certificate 2 🗌 No ☐ Yes 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 10 2 No Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death. Funeral Director: After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No completed filled in by the Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Poh Boon Date filed (Month, Day, Year) 32. Registrar's Signature Registrar DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Year JoAnn McCoy 2:49 A M Medical 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN SQUARE HOSPITAL Rosedale Baltimore 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2X5XF North Carolina Months Days Hours 220-38-69 10/04/1942 Director Usual Residence of Deceden 28a-f shov 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore Middle River 1 🗆 Yes 2 🄀 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1 Funera! items 23a 201 Midlass Drive, Apt. 1A 21220 U.S.A. death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, Give ō 9 1 Never Married 2 Married Black, White, etc. after Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", Completed 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 10 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Luke High Mary Chavis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Meyers (Son) 201 Midlass Drive, Apt. 1A, Baltimore, Md. 21220 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Carmel Cemetery 01/25/2011 Baltimore, Maryland 22. Name and Address of Eacility
Bruzdzinski Funeral Home, P.A.
1407 Old Eastern Avenue, Essex, Maryland 21221 21. Signature of Fame at Terrice Licensee 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ severe Chronic obstructive pulmonary disease sease or condition resulting in death) veass Medical Due to (or as a consequence of): Éxaminer Sequentially list conditions, Physician/Medical Examiner Due to (unas a consequence of, cause. Enter Underlying Cause (Disease or linjury that initiated events attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à of haryngeal and mouth Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should Had Tracheos Tomy and was chronic Ventilator 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed After this certificate dependent x at Least 3 years 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Hospital Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) eral Director: After thi filled in by the funeral 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29h. 29c. License number **D** 005772 STEELE 29d. Date signed (Month, Day, Year) Interel predicine 21 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 FRANKLIN Square DR 21237 Laura STEELE md Balto 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State

Registrar

JAN 25

NCCO

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Maitland John Month Year 2011 5:13AM Medical JANUAN 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Seasons Hospice Randallstown Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign ^{Year}1927 Min Feb. 21 Hours 178-20-6901 83 Pennsylvania Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1321 Providence Road 21286 USA 12, Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify and Mental Hygiene. If Yes, Give Year or Dates Specify: white 3 🗌 Widowed 4 🗌 Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Electri<u>cal Engineer</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James A. Maitland Maymie A. O'Shea 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Cidney P. Maitland wife 1321 Providence Road; Towson, MD 21286 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1. Department of I Important: If it cemetery, crematory or other place) any injury c 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. Cem. 1/27/2011 Owings Mills, MD 21. Signature of Funeral en ce 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, MD 21204 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Alshimers Dementia Immediate Cause (Final Physician/ d-Stage disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury that initiated events. Examine Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Dav Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed' After this certificate 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 2 🗹 No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending 2 🗌 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in thy opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) USRYAPAMINIO 00057465 1/20/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N - 5 · Rajapa ICS C, M · D · 2835 5 miTh 5 mith Av. S-203, Baltimore, MD 21209

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

JAN 25 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene -For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Ρ. Marshall, Jr. Howard Janua M A 10:PO Medical 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sinai of Baltimore Hospital Baltimore n/a Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign May 4, 1925 1 **x** M 2 □ F Months Days Hours Min. Mary Tand Director 212-20-4396 85 Yrs Usual Residence of Decedent fshow 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location Director MD. 1 🗆 Yes 2 😾 No Baltimore Timonium 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 12320 Rosslare Ridge Rd. #101 21093 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates than "natural", 1 ☐ Yes 2 No Specify: 3 Divorced Specify: Completed White injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) and Mental Hygiene. College (1-4 or 5+) Machinist Tool & Dye Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Howard P. Marshall, Sr. Anna M. Lorber Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important; If item 27 is Mildred Marshall/ Wife 12320 Rosslare Ridge Rd. #101 Timonium, MD. 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1-29-11 <u>Druid Ridge Cem.</u> Pikesville, MD 21. Signature of Funeral Pervide Licen 22. Name and Address of Facility
Ruck Towson Funeral Home,
1050 York Rd. Towson, MD. Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death Immediate Cause (Final Physician/ Sepsis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to for selections af: the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or linjury that initiated events signed by the attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Dav Year Unknown g 🗌 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Metastatic disease (cancer Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown fibrillation 24b. Were autopsy findings available prior to completion of cause of death? Dseudoaneury 24a. Was an has ores after death.

eral Director: After this certificate I filled in by the funeral director, pag performed? 2 🗷 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 X No Other: 1 Nation 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury ☐ Accident ☐ Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number MBBS RES - 000 21 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAMITA SINGH MBBS OF BALTIMORE HOSPITAL SINAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

Marshal

Howard

Patient

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 45 am Medical 4a. Facility Name (if not institution, give street and numi Examiner 4b. City, Town, or Location of Death 4c. County of Death Genesis-Severna Park Severna Arunde1 Funeral Social Security Number Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland 1 M 2 F (Month, Day, Months Days Hours Min. Director 215-28-1158 82 Nov Usual Residence of Decedent 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Anne Arundel 1 Yes 2 No Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7950 Bellhaven Avenue 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 2 No 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify. Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) U.S.F.G. Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Co. Actuary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Tansi11 Katherine L. Mitchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley A. Marshall (Sister) 7950 Bellhaven Avenue, Pasadena, Maryland 21122 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Glen Haven Mem Park | Jan.26,2011 Glen Burnie Maryland Signature of Fun at 8 rvice License 22. Name and Address of Facility McCully-Polyniak Funeral Home Mountain Road, Pasadena, Md. 21122 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Implediate Cause (Final set and Deat ∜nysician/ lise e or condition month Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregr 23d Date of delivery 3 Ectopic pregnancy in the past 12 month 5 Other (specify) Pregnant at time of death Month been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an 24b Were autopsy findings available cate has page 2 s prior to completion odeath? autopsy r this certificate had director, page 2 No ☐ Yes 1 🗌 Yes 25. Was case referred to project 26. Place of Death (Check only one) examiner? ၉ 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 28a. Date of injury (Month, Day, Year) Mann of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work Accident 1 Yes Investigation Suicide Could not be n 24 hou. **the Funeral Dire.** حما filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed within 2 To the I only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 50725 MD who completed cause of death (Item 23a) (Type 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2011 Year Anna Marie North Jan 25 3:38A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death tc. County of Death Carroll Carroll Hospital Center Westminster 5. Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Jan 19 **Funeral** 9. Birthplace (State or Foreign Days MD Country) Months Hours 217-01-6086 94 Director Yrs 1911 Usual Residence of Decedent If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at perriit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a, State Director 10c. City, Town or Location 10d. Inside City Limits Westminster MD Carroll 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12 Timber Ridge Dr. 21157 USA 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Specify: white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) State Secretary 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Shafer Elsie Fox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1275 Bird Hill Dr., Westminster, MD Deborah Hopkins-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 1-29-11 injury o Bethel Cemetery Cascade, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Fletcher Funeral any Homas 21157 254 E. Main St., Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of ach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the at d be detached for Unknown 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown phonia peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director. After this certificate has page 2 autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 2 No ပ 1 🗌 Yeş Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 5 Pending work' 1 Yes 2 No Investigation Could not be completed filled in by the Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Pate signed (Month, Day, Year) 1/25/201 3725 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11 Tariq Mahmood, 191 Ridge Rd., Westminster, MD 21157 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar JAN 25 2011 Deneur DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Januan Jan Zemora 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HOWARD COUNTY GENERAL COLUMBIA 1/ospin HOWARD MAKYlUNG Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth 1 - M 2 X F Months 66-12-0550 Hours Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits OLUM 1 Yes 2 □ No ò 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a . Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status 12 Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, ğ 1 Never Married 2 Married Black, White, etc. 'natural", or Baltimore, Maryland 21215-0036 filed within 72 hours after 2 No 1 Yes Completed Specify. 3. ₩ Widowed 4 □ Divorced Specify: Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) ပ Page 1 and 2 should be in ment of Health and Menta 19a. Informant's Name/Relationship (Type, Print) DAU GULER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or otherac 2-201 4 ☐ Donation 5 ☐ Other (Specify) Furieral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Security list of ditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed -tran and that initiated events Due to (or as a consequence of) resulting in death) Last the burialbeen signed by the attending physician should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Director: After this certificate has autopsy performed Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1. Natural injury 5 Pending work death Accident
Suicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours after To the Funeral Direct Medical 29a. Certifier 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

25

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

201-109

32. Registrar's Signature

Sabapalh

D30641

Impre May

Back Liver nick Road

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		4a. Facility Name (if not instituti)	4	b. City, Town,			January 1	4c. Cour	nty of Death	
106 Park Avenue Edgewater Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs						er 24Hrs.	8. Date of Bir		Arundel	thplace (State or		
Director		224-50-4268 1\overline{X} M 2 F 70 Yrs. Months Days Hours Min. 04/08/1940						1Foreig				
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ith the Maryland 23a or 28a-f show notified at once,	Director	10e. Street and Number 106 Park Avenu	e			10f. Zip Code	21037	7	1	og. Citizen of United		-
eath with items 23	Funeral	11. Marital Status 1 Never Married 2 N	12. Was Deceden Armed Forces	?		Decedent of F s, specify Cub					ace - Ameri hite, etc.	can Indian, Black,
after d	Dy F		orced If Yes, Give Year or Dates:	No		Yes 2 X				Specif	_{fy:} Wł	nite
2 hours	ted	 Decedent's Education (Spe Elementary/Secondary (0-12) 	cify only highest grade cor College (1-4 or		16a. Decedent during mo	s Usual Occup st of working li				16b. Kind of	Business/I	ndustry
036 Aithin 7 ene. Ar than	Completed		4	,	Tr	uck Dri	iver			Loca	al Hau	ıling
21215-0036 unid be filed within 7 Mental Hygiene. marked other than cevent, the Medical	Be Co	17. Father's Name (First, Middle Jack D. Nicho						-	irst, Middle, M [erries		me)	
MD 21 id 2 should the lith and Mer in 27 is mar aumatic eve		19a. Informant's Name/Relations Robin D. Niche				Address (Stre Hyde La						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28s-f she injury or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other S		ate Metr	ace of Disposit ematory or othe CO Crem	erplace) atory 1	[nc	01/2	Date 1/2011	20c. Locatio Balti	more.	Maryland
Baltil permit. Departm Imports		21. Signature of Funeral Service	Licensee Alyson	K Tayl	lor 22. Na 299	me and Addre	ss of Facility	Crem d., B	ation Baltimo	Societ re, Ma	y of rylar	Maryland nd 21228
Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause	complications that caused	the death. [o not enter the	mode of dying	g, such as ca	ardiac or re	espiratory arre	st, shock, or	heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Hypertensive A Due to (or as a cons			vascular D	isease					Death
	_	Sequentially list conditions,	b.									
	E I	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a cons									
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8760, rtificate be ing physici as the buri		IF FEMALE: 3b. Was decedent pregnant in the past 12 months?	23c. If yes, outcorne 1 Live birth	ne of pregna	-	I death 3	Ectopic	pregnancy	/	23d. Date Month	of delivery D	ay Year
Box 687 e death certifit the attending 1 ed for use as t	Physician/		4 Pregnant at 9 Unknown	time of deat	h 5 Dthe	er (Specify)		14		1		
i, P.O.	≥	Part II. Other significant condit	ions contributing to death	but not res	ulting in the un	derlying cause	given in Pa	rt I.	23e. Did tot			he cause of death? ably 4 Unknown
Records, The law require ificate has been si r, page 2 should b	Completed								24a. Was a autops	у	prior to co	opsy findings available ompletion of cause of
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/ital /sician: uis certi	8	25. Was case referred to medica examiner? 1 Yes 2 No	Hospital: 1 Inpatie	nt 2 E	R/Outpatient		Other	Check only Nursing H		Residence 6	✓ Other	Scene
Division of Vital tal or Attending Physician rs after death. al Director: After this certi led in by the funeral director	on: To	27. Manner of Death 1 Natural 5 Pend	28a. Date of Inju (Month, Day,Y		8b. Time of Inj	ury 28c. Inj	ury at Work?	? 280	d. Describe ho			
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and trip filled in by the funeral director, page 2 should be detached for use as the burial - transit.	Certification:	3 Suicide 6 Coul	tigation 28e. Place of In	jury - At hom	ne, farm, street,	factory, office	building, etc	281	f. Location (St or Town, Sta		nber or Rur	al Route Number, City
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	ल	29a. Certifier 1 Certifying Pl	nysician: To the best of my miner: Dn the basis of example and manner stated.									
F 3 F 8	¥ .	29b 8igoature and little of certifie		1 no	se		se number .M.E.	_		29d. Date sig January 2		th, Day, Year)
5t/v		30. Name and address of person Victor Weedn MD JD	who completed cause of d Assistant Medical		•	Baltimore \$	Street, Ba	altimore,	MD 21223	3		
Sta Registr	te ar	31. Date filed (Month, Day, Year)	32. Registrar		bares							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Robert B. Ogden 5:10a^M Jan 2011 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Stella MAris Hospice Towson Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign Days 174-16-8483 1 X M 2 🗆 Months Hours Min **Director** 89 20,1921 Usual Residence of Decedent 28a-f show 10a. State with the Maryland the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Essex 1 Yes 2 XNo ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23aFuneral 935 Middlesex Road 21221 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ Yes 2 No Yes, Give 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Electrician Beth Steel 12th Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) LLoyd Ogden Margaret Wixstead 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dale Ogden /son 3620 Almeria Street SanPedro CA 90731 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Holly Hill Cemetery 1/27/1 Baltimore MD 4 Donation 5 Other (Specify) Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21, Signature Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the dath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) END STAGE RENAL DISEASE Medicat Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine ude to (of as a consequence oi). Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Pregnant at time of death 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) 1 Yes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🛣 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar

a.m.

5:10

2011

JANUARY

2300 DULANEY VALLEY RD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JACKIE JONES

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Month Year Bernadine 1930 DM Parker /Medical mycu Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death NA 5. Social Security Number If Under 1 Year If Under 24 Hrs. (In vrs. last birthday) 8. Date of Birth (Month, Day, 02 - 27 - Birthplace (State or Foreign Country)
 MD **Funeral** 1 M 2 XF Months Days Hours Min 220-64-4025 Director 56 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Ilmportant: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, In a marked other traumatic event, In a marked other traumatic event, In a marked other traumatic event, In a marked other traumatic event, In a marked other traumatic event, In a marked other events. 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1⊠Yes 2□No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 USA 4545 Manorview Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. African 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: þ SpecifyAmerican 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Parking Attendant Penn Parking Co. 12th Grade Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Magdaline L. Parker, Roland ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ~212294532 Manorview Road Baltimore, Maryland <u>Tyshell</u> Barnes-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🖾 Burial 2 ☐ Cremation 3 ☐ Removal from State Zion Cem. 01 - 27 - 11Lansdowne, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due lo (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Due to (or as a consequence of) attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>≥</u> 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 1 □ Yes 1 ☐ Yes 2.☐ No director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 □XYes 2 □ No 1 npatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 □ Natural 2 □ Accident 1 ☐ Yes 2 ☐ No within 24 hours after deat To the Funeral Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State edistrar's Signatur

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗎 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Jan Charles Patterson Parker 8:00A M 2011 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 441 Sawgrass Ct. Westminster Carroll If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, May 23 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 🖾 M 2 🗆 F 119-07-4508 **Director** 90 May NY Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Westminster 1 Yes 2 XNo 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 441 Sawgrass Ct. 21158 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 X Widowed 4 ☐ Divorced Specify: white Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Education 12 t. Page 1 and 2 should be filed with trment of Health and Mental Hygien rtant: If item 27 is marked other t njury or other traumatic event, th Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Percy Parker Sadie Patterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Bezon - Daughter 441 Sawgrass Ct., Westminster, MD 21158 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 🗌 Burial 2 Cremation 3 🗌 Removal from State 4 Donation 5 Other (Specify) South Carroll Crem 1-25-11 Winfield, MD 21. Signature Funeral Service Licensee 22. Name and Address of Facility Fletcher Funeral Home Thomas Z St. Westminster, MD 21157 Main 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph. sician/ Due to (or as a consequence of): disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Dav Pregnant at time of death
Unknown Year ate has been signed by the a page 2 should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 🜠 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No After this certificate 1 🗌 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 K Residence 6 ☐ Other (Specify) Director: After this 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural injury 5 Pending Accident Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurse Medical Examiner: On the basis of examination and/or investigation 29a. Certifier the time, date and place, and due to the cause(s) and manner as stated. (Check my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the b only one) of my knowledge ccurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of persor who comple oe, Print) Brevers 70 mls

State

Registrar

Date filed (Month, Day, Year)

25

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Michael Picarello, Jr. anuary /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town, or Location of Death Examiner G165 Umo RG Social Security Number (In yrs. last birthday) 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year Jan 06, 9. Birthplace (State or Foreign Country)
MD **Funeral** Year) 1.2M 2□ F Months Hours Min. 47 220-90-0133 1964 Director Usual Residence of Decedent 10a. State 10b. County 28a-f show 10c City Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Its Medic Itan, in an injury or other traumatic event, Its Medic Itan. Director 1- Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 325 South Furrow Street 21223 Funeral United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 B Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Grasmick Lumber Co. Deliveryman Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) care 110, Paul Paul Michael Picarello, Sr, Darlene Everett 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene Taylor /Mother 3351 Deepwell Ct. Abingdon, MD 21009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Jan Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2011 21. Signature of Funeral Service Licensee 22. Nacramatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause to disease or condition resulting in death) mediate Cause (Final **Physician** /Medical Due to (or as a consequence of): Examiner Osquentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physiclan: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Box 68760; Physician/Medical attending physic for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy 2 No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient this 28a. Date of Injury (Month, Day, Year) filled in by the funeral 27. Manper of Death 28b. Time of After 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending after death 2 Accident investigation 1 ☐ Yes 2 No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗀 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) the within 2 29b. Signature and title of certifier 29c. License number Mylan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

K-Tonya Mason, 900 5 Caton Ave Baltimore, M) d 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 25 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Dolores K. Primavera 2011 1830 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford **Examiner** Upper Chesapeake Medical Center Bel Air 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Balt. Maryland , 1930 **Director** 80 October 214-26-6715 Usual Residence of Decedent rral", or items 23a or 28a-f shor Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Harford Joppa Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?

United States

of America Funeral 21085 205 Frazier Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2★No 14 Race - American Indian. Black, White, etc. white þ 1 Never Married 2 Married 1 Yes 2XXNo Specify: If Yes, Give Year or Dates "natural", Completed 3 X Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 7 in and Mental Hygiene.
7 is marked other than than Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) **Doris Hughes** Maryland 17. Father's Name (First, Middle, Last) ျှ Russell William Eckert other traumatic 19a. Informant's Name/Relationship (Type, Print)
Marlyn F. Peterson/ sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 Frazier Court Joppa, Maryland 21085 e 1 and 2 s of Health If item 27 Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State conetery crematory of other place)
Dulaney Valley
Memorial Gardens January Burial 2 Cremation 3 Removal from State ö Department of Important: If any injury or once. 2011 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility
Peaceful Alternatives Funeral and Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 . Fart 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Orset and Death Immediate Cause (Final BACTEREMIA Physician/ TREP disease or condition resulting in death) Medical **Examiner** Cellul Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) he burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Day Month Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown signed by the ar 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 nknown Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? Hospital or Attending Physician: The I 24 hours after death. Funeral Director: After this certificate h No 1 🗌 Yes Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? examiner? Hospital 1 DOA Other: Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No injury 1 Natural 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a To the Funeral C Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature at 00056296 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Birnbaum M.D. 500 Upper 32. Registrar's Signatur State Registrar

January

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ De 1045A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 76 Peppermint Lane Middle River Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last hirthday) 8. Date of Birth
(Month, Day,
June 1, **Funeral** 9. Birthplace (State or Foreign 1**X** M 2 □ F Day, Year) 1. 1943 Months 215-40-1615 Director 67 Maryland Usual Residence of Decedent or 28a-f shov permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notitied at any injury or other traumatic event, the Medical Examiner must be notified at ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore Middle River 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 76 Peppermint Lane 21220 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates White Completed 3 Widowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) N/A College (1-4 or 5+) Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ William E. Popp Beatrice V. Stevens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Blanche Popp/ Wife 76 Peppermint Lane, Middle River, MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or ot.

Jarrettsville 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jarrettsville, MD 25, 2011 Signature of Funeral Service Licensee Name and Address of Facility ans Funeral Chapel & Cremation Services 000 Harford Rd. Parkville, MD 21234 22. Name and Address of Facility Evans Funeral Cha 18800 Harford Rd. art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Incrediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Due to for es a nonsequence on Examin cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death signed by the a 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed should been Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy perform certificate 1 ☐ Yes 2 ☐ No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 1 Tes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this . Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 😾 Natural 5 Pending 1 🗌 Yes after death Director: filled in by the Accident Investigation Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OV BOR

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Physician/ Mary Jane Paquette 10:35 A January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Encore At Turf Valley Ellicott City Howard If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Oct 30, 1923 9. Birthplace (State or Foreign Country)
Pennsylvania Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Min 1 🗆 M 2 💢 F 87 189-12-2952 Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Ellicott City 1 Tes 2X No Howard Maryland 10g. Citizen of What Country? Funeral **USA** 11150 Resort Road 21042 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Yes 2 X No Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 X No Specify: 3√ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Mary Josephine O'Donnell Robert Francis Joyce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1656 Woodstock Road Woodstock, MD 21163 Nadine Corbett, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Metro Crematory Inc. 01/24/11 Baltimore, Maryland Signature of Funeral Service License Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryl Thomas Gregor Lomas Marvland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Dementia Physician/ - na a disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Dav Year 4 Pregnant : 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Mother (Specify) 2 **N** No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ligan Rd, Ellicott city, MD 3621 Andres ar JAN 25 32. Registrar's Signature Day Year) State 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 2. Date of Death 3. Time of Death Physician/ P^{M} 2011 9:55 Thomas Rowan Eugene January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 10230 Wesleigh Drive Columbia Howard 7. Age (In yrs. last birthday) Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Months Davs Hours Min. Aug 3, 1935 Maryland 220-28-7683 Director 75 Usual Residence of Decedent 28a-f show 10b. County 10a. State Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral United States 10230 Wesleigh Drive 21046 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Yes, Give 72 hours after Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. Specify: Completed 3 Widowed 4 Divorced White Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry should be filed within 72 n...h and Mental Hygiene. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Math Educator Education Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important; If item 27 is marked Beatrice James Rowan Mary Ryan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra K. Rowan/wife 10230 Wesleigh Drive Columbia, Maryland 21046 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 1/25/2011 Woodbine, Maryland 21. Signa re of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 any. Rahomes M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ VEACS disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of Cause (Disease or iinjury that initiated events burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be execute Due to (or as a consequence of): resulting in death) Last Physician/Medical phys the b Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Month Year Pregnant at time of death 2 🗌 No as been signed by the 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy After this certificate has page perform 1 🗆 Yes 2 🗖 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 🗡 No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work?
1 Yes 2 No 5 Pending 1 Natural s after death Accident Investigation the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State, within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)
JAN 25 201

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			4 17	partment of Health and N	/lental Hygie	ene 2011	011.88
			Registrar	ertificate of Death		. No.	01900
	Physicia		1. Decedent's Name (First, Middle, Last) Julian Q. Ross Jr.		2. Date of Death Jan 24	1 Day 201 Tear	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	14.00%
			513 Crisfield Road	Middle River		Baltimo	re
100	Funeral		5. Social Security Number 6. Sex 7. Age (<i>ln yrs. last birthda</i>) 2 1 8 − 2 2 − 9 0 4 4 1 ★ M 2 □ F 8 2 Yrs.) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	g. Birthi	place (State or Foreign
	Director		218-22-9044		Sept.30		MD
	nd ihow at	5	10a. State 10b. County 10c. City, Town or	Location		1	Od. Inside City Limits
	faryla 8a-f s tified	Director	MD Baltimore Midd	le River			1 Yes 2 No
	the N or 2	<u></u>	10e. Street and Number	10f. Zip Code	100	J. Citizen of What Cour	ntry?
	s 23a sust k	Funeral	513 Crisfield Road	21220		USA	
	death item ner n	Ē	Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
30	after al", or xami	d by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 2 No If Yes, Give Year or Dates	1 ☐ Yes 2 ☐ No Specify:			ite
9500-c	atura ical E	Completed	real of Dates.	edent's Usual Occupation	16	b. Kind of Business Inc	dueto.
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7	withi giene ner th		12th Ya	rdmaster	I	P.P.R. Ra	ilro _{ad}
yland	e filed tal Hy ed oth	To Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Mai		
713	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inmportant: I firem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	_	Julian Q. Ross Sr.			DiBlasi	
Z Z	2 sho th and 27 is u	7	I . III	iling Address (Street and Number or Rura 3 Crisfield Roa		-	Code) MD 21220
a)	and Heal tem 2		· · · · · · · · · · · · · · · · · · ·			c. Location - City or To	
altimore,	age ent o			ematory or other place) ill Cemetery 1/		Baltimore	
alt	permit. F Departm Importa any inju			22. Name and Address of Facility 30			
Ď	Pe III	10	Ministra Bare	Connelly Funer	al Home	of Essex	21221
			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
P	h_sician/	11	Immediate Cause (Final disease or condition	ell Bladder	Cancer		Onset and Death
The same of the sa	Medical Examiner	Ш	resulting in death) Due to (or as a consequence of):				
		Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
7	ansit	Examiner	Cause. Enter Underlying Cause (Disease or linjury				
	execuan an and rial-tra	Ex	that initiated events c. Due to (or as a consequence of):				
or Attending Description The law requires that the death continued to	care be executed physician and the burial-transit	dical	d				
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ă -	by the a trached it	Physician/M	1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Suy (Su
ָר בַּ	rriat tr	by Pł	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	couse contribute to th	e cause of death?
הַ בּ	r requires triat. S been signed to should be detailed.				1 Ves	2 No 3 Prob	oably 4 🗆 Unknown
Ords,	s pee	plet			24a. Was an		osy findings available
בו ביולים ביולים	certificate has rector, page 2 a	Completed			autopsy performed 1 \(\sum \) Yes 2	death?	mpletion of cause of
ָ קוֹ ק	certificate ector, pag		25. Was case referred to medical examiner?	26. Place of Death (Check			
N N	this or	မ	1 ☐ Yes 2 ②No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati		me 5 Residence	e 6 🗆 Other (Specify))
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the Heepital	on the hospital of Arterioning This within 24 hours after death. To plete Funeral Director. After the completed filled in by the funeral process.	Medical	29a. Certifler 1 Certifying Physician: To the best of my knowledge, death (Check 2 Medical Examiner: On the basis of examination and/or involved.	n occured at the time, date and place, an estigation, in my opinion, death occurred at	d due to the cause(s	s) and manner as stated lace, and due to the cau	d. use(s) and manner stated.
ro tho	within 2 To the comple	ž	only one) 3 ☐ Certifying Nurse Practioner: To the best of my knowledge 29b. Signature and title of certifier A	, death occurred at the time, date and place	e, and due to the cau	se(s) and manner as sta Date signed (Month, L	ated.
			· Wanke Wills, ME	D00363			2011
			30. Name and address of person who completed cause of death (frem 23a) (Type WANDA WICKS, MD 7)	Doo363 Print) Security	B(vd.	Beltim	ore nu
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	t			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Julia Spine Raab January 23, 2011 10:05 AM Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth Month, Day, Year)
June 28, 1940 1 □ M 2 🛣 F Days Hours 216-38-4151 70 Baltimore, MD **Director** Usual Residence of Decedent 28a-f show 10a. State iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director MD Baltimore Parkville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7902 Ardmore Avenue 21234 United States hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🎇 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) G.B.M.C. the Administrative Support Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stephen J. Spine, Jr. Anna Elizabeth Marecki 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Frederick Raab, Jr. 7902 Ardmore Avenue, Parkville, MD 21234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State More Land Memorial Park January 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 26, 2011 Parkville, MD Signature of Funeral Service Licensee Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) 116 Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months? Month Pregnant at time of death ate has been signed by the a page 2 should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy burs after death.

eral Director: After this certificate I filled in by the funeral director, pag 1 ☐ Yes 2 № No 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🔊 No Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) Wospus 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State within 24 hours a 29a. Certifier 👠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on nd title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 23 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M 6701 MA LES 31. Date filed (Month, Day, 32. Registrar's Signature State JAN 25 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month R1665 19 Zol I 36 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day Year)

Oct. 1953 5. Social Security Number Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 🗌 M 2 🖊 F Months Director Vrs Mary Tand 217-52-6726 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at one. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Anne Arundel Annapolis 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 920 President St; Apt S-1 21403 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Armed Forces? Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates black 1 ☐ Yes 2 K No Specify: 3 Divorced 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 cashier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Johnson Dorothy Mae Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David R. Queen - son Broach Ct; Annapolis, Maryland 21401 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of): Approximate Interval Between Onset and Death Ph_{sician}/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if an leading to immediate cause. Enter Underlying Examine Due to or as a consequence of Cause (Disease or linjury sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months? Pregnant at time of death Month Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 1 ☐ Yes 2 ☐ No Yes 2 N funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 \sum Yes 2 \sum No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 🔲 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EFENSE

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month William Watson Stewart 2011 1:00 P M Medical January 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 10211 Montgomery Avenue Kensington Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Jun 18, 1 Funeral 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 X M 2 □ F Months Hours New Jersey Director 072-18-7590 88 Usual Residence of Decedent show or 28a-f show notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Maryland Montgomery Kensington 1 X Yes 2 No 10e. Street and Number ō "natural", or items 23a or edical Examiner must be i 10g. Citizen of What Country? Funeral 10211 Montgomery Avenue 20895 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: 3 Widowed 4 Divorced Specify: Completed Year or Dates. 1943-47 White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) l Hygiene. I o**ther than** " Elementary/Seconday (0-12) College (1-4 or 5+) 4 Executive Insurance Company Be traumatic event, permit. Page 1 and 2 should be flied Department of Health and Mental Hy Important: If item 27 is marked othany injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ William Watson Stewart, Sr. Ruby Goodman Selden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary P. Stewart/wife 10211 Montgomery Avenue Kensington, Maryland 20895 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 K Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 1/25/2011 Woodbine, Maryland Sign ure of Funeral Service Licenses 22. Name and Address of Facility
Going Home Cremation Service P.O.
M00957 Beverly L. Heckrotte, P.A. Clarks thomas 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Onset and Death Congestive Heart Failure disease or condition years Medical resulting in death) Due to (or as a consequence of) Examiner Ischemic Cardiomyopathy Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or iinjury that initiated events years Examine Due to for as a sonsequence on burial-transi attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Pregnant at time of death Other (specify) Month Dav Year Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an pate has bage 2 s autopsy performed certificate 1 ☐ Yes 2 ☐ No Yes r this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending injury Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 24 hours Medical within 24 hor To the Fune completed fil 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D37142 January 24, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Coleman, M.D. 1355 Piccard Drive Rockville, Maryland 20850 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

JAN 25 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Stair John Medical :55 201 January 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death Frederick <u>Kline House</u> Airy Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth **Funeral** Birthplace (State or Foreign Country) (Month, Day, Year, 27, 19 1 🗙 M 2 🗆 F Months Days Hours Min Director 220-58-3195 58 Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heaith and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Maryland 1 🗌 Yes 2 🔀 No Frederick Mt. Airy 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 7000 Kimmel Road 21771 United States 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. Completed by 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify 3 Divorced 4 Divorced Specify: White Year or Dates Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Janitor Department of Energy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Allen Clark Stair Elizabeth Scarlett Joesphine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21701 Terri Kim Williams/sister 332 South Jefferson Street Frederick, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot 1 Durial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 1/25/2011 Woodbine, Maryland 21. Sign pre of Funeral Service Lice 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 stimou Beverly L. M00957 Heckrotte, P.A. Clarksville, Homas 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between ARENOCARCINOMA Immediate Cause (Final Onset and Death OF THE LUNG Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) the attending physician and the for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death Month Day Year detached 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown completed filled in by the funeral director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: ပ 1 🗌 Yeş 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Copice After this 27. Manner of Death Date of injury (Month, Day, Year) 28b, Time of Certificate; 28c. Injury at work? 28d. Describe how injury occurred **№** Natural 5 Pending 1 \square Yes 2 No Accident Investigation after death 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Deficiency hydrogen in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of cert ٥ 29c. License number 29d. Date signed (Month, Day, Year) MB 131761

State Registrar

501

WI SEVENTA ST.

MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) O'CONNOR

31. Date filed (Month, Day, Year)

JAN 25 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Mary Elizabeth Schmidt 21 Day 201 Far Jan 7:50 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Finksburg Carroll 1924 Bethel Rd. 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2X □ F Months Hours MD Country) 214-24-4818 82 Director Usual Residence of Decedent or 28a-f show be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Finksburg 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1924 Bethel Rd. 21048 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Completed by 1 Never Married 2 Married 2**X** No Yes Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Education 8 Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George Albert Rinehart Mary Belle Hare 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lori Schmidt Garber-daughter 1924 Bethel Rd., Finksburg, MD 21048 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Important: If it any injury or o Burial 2 Cremation 3 Removal from State 1-25-11 Sykesville, MD Lake View Memorial 4 Donation 5 Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility Fletcher Funeral Home lowline 254 E. Main St., Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (o a consequence of): Examiner Stive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as sonsequence of) Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed Hyperten Sico 1 Yes 2 No 3 Probably 4 Unknown behachive 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an After this certificate has autopsy 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check To the within 2 only one) 29b. Signature and title 29c. License number 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item Ba) (Type, Print) MD428 24 North 518 ST

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)
JAN 2 5 2011

32. Registra

PA1732

1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 5 2011 AULINE /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 8. Date of Birth (Month, Day, Ye 9/21/1926 7. Age (In yrs. last birthday) 24 Hrs If Under 1 Year | If Under Security Number 9. Birthplace (State or Foreign Country), NC **Funeral** Months Min Days Hours 1 □ M 2 7 F 84 Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 □ No Be Completed by Funeral Director トクロ 10g. Citizen of What Country? 10e. Street and Numbe USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) USTOCILA Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) WILDER WILLIAM ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21) WIL Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 10220 GUIL FORD Ped. P. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final foiluse to thrive **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner emention Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregrant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use coptribute to the cause of death? Division of Vital Records, ð 2 No 3 Probably 4 Unknown 1 🗌 Yes filled in by the funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manuer of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 🗆 No 2 Accident 24 hours after deatle Funeral Director; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Lecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1001009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) slone suite 1A, Annopolis Tideworder 32. Regist ar's Signature 31. Date filed (Month, Day, State

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TITEM 7,8,9 per FH, G911, 725 / 2011, WS

State of Maryland / Department of Health and Mental Hygiene?

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 20° 201 Ta Schatzkin Arthur 7:57 a. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 4001 Thornapple St. Chevy Chase Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 6. Sex 1 ∰ M 2 ☐ F 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** ^{Year)} 1948 Days (Month, Day, Feb. 11 Months Hours Min. 148-40-7930 62 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified any once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 4001 Thornapple St. 20815 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates. 1969-70 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) **5+** Elementary/Seconday (0-12) Physician-Epidemiologist Research Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Ellen Gould. Harvey Schatzkin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (WIFE) Tamara Beth Harris Schatzkin Thornapple St., Chevy Chase, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 1/21/2011 Beltsville, MD 22. Name and Address of FacilityRapp Funeral & Cremation Service . Signature of Funeral Service Ligensee MO0382 933 Gist Ave. Silver Spring, Maryland 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death YEAR Immediate Cause (Final Ph_sician/ GLIOBLASTOMA MULTIFORME disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been shown by the control of the contr Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE f yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was ar page 2 autopsy perform death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2XX No 1 Yes 2 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Tes 2**X**] No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 XResidence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending 1 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MD00043361 JANUARY 20, 2011 24+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NW #1-200, WASHINGTON D.C. 0037 2150 PENNSYLVANIA AVE. S. SIEGEL M.D.,

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 21 ZYear Barbara Sherman Month 11:50A Medical Eacility Name (if not Institution, live street and number Examiner 4c. County of Death Ustown 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, 9:50 Birthplace (State or Foreign Country) **Funeral** Director 68 ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits 1 ☐ Yes 2 🜠 o 10f. Zip Code 10g. Citizen of What Country? 2120= 12 Was Decedent Ever in LLS 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Yes 2 No Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 No Specify: 3 - Widowed 4 - Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done fe. DO NOT use retire) Elementary/Seconday (0-12) Be Father's Name (First, Middle s Name (First, Middle. ျှ bones 6005 Har 20b. Place of Disposition (Name of cemeter, crematory or other place, thod of Disposition Department of Important: If it 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) . Sig thre of Funera Service I 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ End-Stage multiple Sclenosis disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s autopsy performed Yes 2 No 2 No 1 Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Vottler (Specify) Hospital: 1 🗌 Yes 2 🗹 No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation after deat Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide within 24 hours a To the Funeral Completed filled Medical 29a. Certifier 🛂 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) nsRajapalone M.D D0057465 1121/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 Smilh M-703, Baltimore, MD 21200 Rajapakse MID 32. Registrar State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ TANUARY ROBERT 03:50 A M SCHERR Medical 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SPITAL 1+0 INA BALTIMORE N/A 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 8. Date of Birth 1 X M 2 - F Months Days Hours 0972571916 Director 217-03-6898 94 Yrs. Usual Residence of Decedent 28a-f show 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits CHERA, Aussai N/A 1 X Yes 2 No BALTIMORE 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 6943 BROOKMILL ROAD 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? "natural", or Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ី No Specify: If Yes, Give Year or Dates 3 ☐ Widowed 4 ☐ Divorced Completed WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ant; If item 27 is marked other than ' life. DO NOT use retired) Elementary/Seconday (0-12) DISTRIBUTOR BALTIMORE SUN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ABRAHAM SCHERR FANNIE CAPLAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JUDY COHEN / DAUGHTER 7220 DENBERG ROAD, BALTIMORE, MD 21209 Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of I 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) KNESSETH ISRAEL 01/24/2011 ANNAPOLIS, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature of Funeral Service License 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or imjury signed by the attending physician and d be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HRONIC KIDNEY DISCASE 1 Yes 2 No 3 Probably 4 Unknown certificate has been ANEMIA 24a. Was an 24b. Were autopsy findings available prior to completion o death? autopsy performed 2 1 No Yes 2 № No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ည 1 Tes 2 1 No Other: After this of funeral dire 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Mann f Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; A: completed filled in by the fu Accident Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 2011 6V 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL OF BALTIMORE. SINAI State 32. Registrar's Signature Darks Registrar

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Shen 125 F M anvar 2011 10 m 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) Months Days 1 X M 2 🗆 F Taiwan 6/13/1949 540-60-8891 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 🕅 No Springfield Fairfax 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? U.S.A 22151 5750 Heming Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married 1 _ Yes If Yes, Give Asian 1 ☐ Yes 2 👿 No Specify 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Physical Oceanography 5+ Scientist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Winnie Shen Marty Y. Shen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Olivia Shen - Wife 5750 Heming Ave., Springfield, VA 22151 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1/13/2011 4 Donation 5 Other (Specify) Falls Church, VA 22042 National Crematory 22. Name and Address of Facility m01539 National Funeral Home 7482 Lee Highway, Falls Church, VA 22042 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final pancreatic disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter orderlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death?

The law requires that the death certificate be executed physician and as the burial-trans Division of Vital Records, P.O. Box 68760, as d by the at detached f Hospital or Attending Physician; after death

Director: A

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Physician

/Medical

Examiner

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VA

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Ith and Mental Hygiene. 27 is marked other than "r r traumatic event, the Med

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

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ed by	Part II. Other significant conditions con	minuting to death but not les	diting in the dilderyin	g cause given arr arr.	1	2 No 3 Probably 4 Onknown					
Complete	-				24a. Was an autopsy performed?						
-	25. Was case referred to medical			26. Place of Dea	ath (Check only one)						
To Be	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3 🗆 [lome 5 Residence	e 5 Residence 6 Other (Specify)						
	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred						
Certification	3 Suicide 6 Could not be determined	28e. Place of injury - At ho building, etc. (Specify		ry, office	28f. Location (Street: City or Town, Stat	and Number or Rural Route Number, e)					
edical C			(s) and manner as stated. Ind place, and due to the cause(s)								
Me	29b. Signature and title of certifier		2	9c. License number	29d. D	ate signed (Month, Day, Year)					

RES - 000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RONGUIL

600 North Wolfe St, Baltimore, MD, 21287

January

II

2011

31. Date filed (Month, Day, Year) State Registrar

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Shirley E. St. John Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gien Burnie Anno Arunde Baltimore Washington Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 2, 1925 5. Social Security Number 9. Birthplace (State or Foreign Funeral Hours Maryland 1 □ M 2 🔯 219-20-8324 Director Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director Maryland Anne Arundel Glen Burnie 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö "natural", or items 23a or Funeral 21061 1102 Nottingham Drive United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify:White 3 ₺ Widowed 4 □ Divorced Completed traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than Elementary/Seconday (0-12) College (1-4 or 5+) Billing Clerk Manufacturing is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Hazel Davis Russell Joyner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other trains John D. St. John / Son 1102 Nottingham Dr., Glen Burnie, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Lakeview Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, Maryland on unera 😽 rvice Lic insee Name and Address of Facility
Kirkley-Ruddick Funeral Home, P.A.
421 Crain Hwy., S.E., Glen Burnie, ture MD 21061 23a. Part 1) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or s a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) anding physician and use as the burial-transit Hospital or Attending Physician: The law equires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Month 5 Other (specify) Pregnant at time of death signed by the aid be detached for 9 Unknown 9 Unknow P.O. other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown Completed this certificate has been s ral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 1 🗌 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\subseteq\) Nursing Home 5 \(\subseteq\) Residence 6 \(\subseteq\) Other (Specify) Hospital 2 No 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA ္ funeral 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director. After completed filled in by the funer work? 5 Pending Vatural 2 🗌 No 2/ Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GAV 301 31. Date filed (Month, Day, Year, 32. Registrar's Signature State JAN 25 2011 ank Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.